XVIII of the Social Security Act to extend the availability of medicare cost contracts for 10 years.

S. 1292

At the request of Mr. EDWARDS, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 1292, a bill to amend the Internal Revenue Code of 1986 to allow a credit against income tax for dry and wet cleaning equipment which uses non-hazardous primary process solvents.

S. 1499

At the request of Mr. KERRY, the name of the Senator from Oregon (Mr. SMITH of Oregon) was added as a cosponsor of S. 1499, a bill to provide assistance to small business concerns adversely impacted by the terrorist attacks perpetrated against the United States on September 11, 2001, and for other purposes.

S. 1520

At the request of Mr. BAYH, the names of the Senator from Maryland (Mr. SARBANES) and the Senator from Virginia (Mr. ALLEN) were added as cosponsors of S. 1520, a bill to assist States in preparing for, and responding to, biological or chemical terrorist attacks.

S. 1530

At the request of Mr. HOLLINGS, the name of the Senator from Maryland (Mr. SARBANES) was added as a cosponsor of S. 1530, a bill to provide improved safety and security measures for rail transportation, provide for improved passenger rail service, and for other purposes.

S. 1539

At the request of Mrs. CLINTON, the names of the Senator from North Carolina (Mr. EDWARDS) and the Senator from Maryland (Mr. SARBANES) were added as cosponsors of S. 1539, a bill to protect children from terrorism.

S. 1552

At the request of Mr. HARKIN, the name of the Senator from Minnesota (Mr. DAYTON) was added as a cosponsor of S. 1552, a bill to provide for grants through the Small business Administration for losses suffered by general aviation small business concerns as a result of the terrorist attacks of September 11, 2001.

S. 1567

At the request of Mr. ENZI, the names of the Senator from Pennsylvania (Mr. SANTORUM) and the Senator from North Carolina (Mr. HELMS) were added as cosponsors of S. 1567, a bill to foster innovation and technological advancement in the development of the Internet and electronic commerce, and to assist the States in simplifying their sales and use taxes.

At the request of Mr. ENZI, his name was withdrawn as a cosponsor of S. 1567, supra.

S. RES. 171

At the request of Mr. FRIST, the names of the Senator from Delaware (Mr. BIDEN), the Senator from Oregon (Mr. SMITH), the Senator from Illinois (Mr. DURBIN), the Senator from Florida (Mr. NELSON of Florida), the Senator from Louisiana (Ms. LANDRIEU), the Senator from New Jersey (Mr. TORRICELLI), and the Senator from Virginia (Mr. ALLEN) were added as cosponsors of S. Res. 171, a resolution expressing the sense of the Senate concerning the provision of funding for bioterrorism preparedness and response.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. LIEBERMAN (for himself and Mr. ENSIGN):

S. 1585. A bill to establish grant and scholarship programs to enable hospitals to retain and further educate their nursing staffs; to the Committee on Health, Education, Labor, and Pensions.

Mr. LIEBERMAN. Madam President, I rise today to introduce the Hospital Based Nursing Initiative Act, a bill that will create new and innovative incentives to lessen the impact of the critical shortage of nurses in our Nation's hospitals. I am very pleased that my respected colleague, Senator JOHN ENSIGN, is joining as sponsor of this legislation/

Before I get into the specific about the bill, I'd like to talk about the overall condition of nursing in America for a moment. Several studies have been completed in the past year that show troubling trends developing in this historic profession. Take for example, the study that reflects a 41 percent dissatisfaction rate among nurses in America, higher than the dissatisfaction rate in most other countries throughout the world. Think about that for a moment, 4 out of 10 nurses in America are dissatisfied with their profession.

Another study reveals that nearly one third of nurses under the age of 30 plan to leave the nursing profession within the next year. In addition, the average age of nurses in America is 45, with many nurses headed toward early retirement. We cannot afford to lose both the older and younger nurses at the same time. Further, while the number of people that are being hospitalized may continue to decrease, those people who are being admitted are sicker and need more intensive nursing care. Not a very rosy picture for patients who are sick. We need to ask will there be someone to provide care for them?

The shortage of nurses has severely affected the health care industry. And hospitals have been hit the hardest since nearly 60 percent of nurses work in hospitals. Further, we know that when nurses have more autonomy, greater control and input into the decision making process, and better communication with physicians and hospital administration, they are more likely to experience greater job satisfaction and stay in their jobs longer. These very tenets make up the American Nurse Credentialing Center's ''Magnet'' accreditation process of nursing services at hospitals. As a result, Magnet hospitals lead the way in attracting and retaining nurses.

Many hospitals have begun to take these steps already. But more must be done. There must be incentives for hospitals to revise their management principles to improve the quality of the work environment in the hospital, initiate aggressive retention programs for nurses currently working in the hospital setting, and create the types of programs that will increase personal and professional satisfaction for the nurses in their facilities.

That is why I am introducing the Hospital Based Nursing Initiative Act of 2001. This bill will create innovative incentives for hospitals that have taken the first steps in developing aggressive retention techniques and develop a scholarship program for hospital-based nurses to return to school on full tuition scholarship to complete a nursing degree.

The first component of this bill will create a competitive grant program that would provide funds to hospitals of up to $600,000 based on staffed bed size for nursing services to use to bolster their retention efforts and improve the work environment for the nursing staff in the hospital. These grants would be made available every two years on a competitive basis. Several major nursing and hospital organizations, such as the American Hospital Association, American Nurses Association, American College of Health Care Executives, the American Organization of Nurse Executives, the American Academy of Nursing, the Pennsylvania State Nurses Association and the American Federation of Hospitals have wholeheartedly endorsed this bill. I am pleased that legislation which incorporates a number of ideas in this bill is moving toward markup in the Senate Health, Education, Labor and Pensions Committee. I appreciate the cooperative spirit with which members of the committee have worked together on these ideas.

The second part of my bill would allow nurses who work in hospitals to return to school on a full tuition scholarship in order to complete a Bachelor of Science in Nursing. This ''Bridge'' scholarship program targets the nearly 55 percent of the nursing workforce who hold an Associate's Degree in Nursing or Diploma in Nursing. Under the Bridge program, nurses will have up to three years to complete the Bachelor's degree. In turn, nurses who accept the scholarship must agree to work in the sponsoring hospitals for the same number of months that they receive scholarship funding. This program is a win-win situation: It provides ongoing advanced education for nurses who seek a higher level of training and we keep skilled nurses working in our hospitals.

We have the opportunity to make a difference. With the bill that Senator

ENSIGN and I are now introducing, we can take the necessary steps to thwart the nursing shortage and provide the critical incentives for hospitals to retain their nurses. We must do all we can to improve job satisfaction for nurses, provide them with opportunities for advanced education, and keep nurses on the job. The Hospital Based Nursing Initiative is the right bill at the right time. I urge my colleagues to support this legislation and help ease the burden on hospitals and nurses in our hospitals.

I ask unanimous consent that the text of the bill be printed in the RECORD. I further ask unanimous consent that letters supporting this legislation and its approach from each of the organizations I cited above likewise be printed in the RECORD.

There being no objection, the bill and additional material was ordered to be printed in the RECORD, as follows:

S. 1585

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Hospital-Based Nursing Initiative Act of 2001''.

SEC. 2. FINDINGS.

Congress finds that—

(1) a Department of Health and Human Services study found a correlation between the number of registered nurses on the staff of a facility and patient health outcomes;

(2) studies have shown that hospitals that promote greater autonomy for nurses, greater nurse control and input into the decision-making process in the hospital setting, better communication between nurses and physicians, and input from nurses at the executive level in the hospital lead to increased retention of and satisfaction for nurses;

(3) the job dissatisfaction rate among nurses in the United States, 41 percent, is higher than in most other countries;

(4) ⅓ of nurses under the age of 30 are planning to leave the nursing profession within the next year;

(5) hospitals employ nearly 60 percent of the entire nursing workforce;

(6) while the number of inpatient hospitalizations is expected to continue to decrease, the acuity of those patients requiring hospital stays is expected to increase;

(7) the projected supply of registered nurses is anticipated to grow at a rate of less than 1.5 percent per year through the next 8 years, while the demand rate (growth) is projected to be over 21 percent per year;

(8) there must be incentives for hospitals to revise management principles to improve the quality of the work environment in hospitals, initiate aggressive retention programs for the nurses currently employed in hospital settings, and employ aggressive recruiting tactics to attract nurses back to hospital settings; and

(9) while numerous hospitals have begun to take the necessary steps to address these issues, Congress recognizes the need for intervention and stimulus.

SEC. 3. NURSE GRANT AND SCHOLARSHIP PROGRAMS.

Title VIII of the Public Health Service Act (42 U.S.C. 296 et seq.) is amended by adding at the end the following:

''PART H—NURSE GRANT AND SCHOLARSHIP PROGRAM

''SEC. 851. DEFINITIONS.

''In this part:

''(1) DIVISION.—The term 'Division' means the Nursing Division of the Bureau of Health Professions of the Health Resources and Services Administration.

''(2) NURSE LEADERSHIP.—The term 'nurse leadership' includes—

''(A) nurse executives;

''(B) nurse administrators; and

''(C) nurse managers.

''(3) PROFESSIONAL NURSE.—The term 'professional nurse' means a registered nurse who holds a valid and unrestricted license to practice nursing in a State.

''SEC. 852. QUALITY OF WORK ENVIRONMENT AND RETENTION GRANT PROGRAM.

''(a) AUTHORIZATION OF GRANTS.—The Secretary may award grants to hospitals—

''(1) to improve the quality of the work environment in hospitals;

''(2) to initiate aggressive retention programs for nurses employed in hospitals; and

''(3) to employ aggressive recruiting tactics to attract nurses back to hospitals.

''(b) APPLICATION.—

''(1) DEVELOPMENT OF APPLICATION FORM.—Not later than October 1, 2002, the Secretary shall develop an application form that a hospital shall use in applying for a grant under this section.

''(2) SUBMISSION.—Each hospital desiring a grant under subsection (a) shall submit an application to the Division at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(3) DUTIES OF THE DIVISION.—The Division shall—

''(A) review each application submitted under paragraph (2); and

''(B) not later than 30 business days after receipt of an application submitted under paragraph (2), forward the application to the Secretary with a recommendation as to whether the Secretary should award a grant to the applicant.

''(4) DUTIES OF THE SECRETARY.—Not later than 30 business days after receipt of an application from the Division under paragraph (3), the Secretary shall determine whether to award a grant to the applicant.

''(c) GRANT APPROVAL CRITERIA.—

''(1) PRIORITY CRITERIA.—The Secretary shall give priority in awarding grants under this section to hospitals that have not previously received a grant under this section.

''(2) REQUIREMENTS.—Before awarding a grant under subsection (a), the Secretary shall assure that the hospital meets the following criteria:

''(A) MULTIPLE GRANTS.—The hospital has not received a grant under this section during the previous 2 year period.

''(B) SYSTEM OF PATIENT OUTCOMES MEASUREMENT.—

''(i) IN GENERAL.—The nurse leadership and professional nurses of the hospital have developed a system of patient outcomes measurement.

''(ii) DELIVERY OF CARE.—The system of patient outcomes measurement under clause (i) evaluates the specific care needs of the patients served by the hospital and the educational needs of the nursing staff of the hospital to ensure that the care the hospital is providing is meeting the needs of the patients.

''(iii) FUNDING.—The hospital allocates sufficient funds to carry out the system of patient outcomes measurement under clause (i).

''(C) DECISIONMAKING.—

''(i) MULTIDISCIPLINARY APPROACH.—The hospital uses a multidisciplinary decision-making process that incorporates the input of the nursing staff of the hospital when refinements, resulting from the evaluation under subparagraph (B)(ii), are developed.

''(ii) PARTICIPATION IN DECISIONMAKING.—The nurse leadership of the hospital has developed and implemented policies and practices that—

''(I) ensure participation of the nursing staff of the hospital in the decisionmaking processes of the hospital; and

''(II) foster the nursing staff's ability to maintain autonomy in the delivery of care.

''(D) NURSE EXECUTIVE PARTICIPATION.—The nurse executive in the hospital participates and provides input in all facets of senior level management as a member of the executive team of the hospital.

''(E) NURSE RETENTION COMMITTEE.—The nurse leadership of the hospital has organized a Nurse Retention Committee that—

''(i) includes nursing staff representatives from the various nursing specialties practicing in the hospital;

''(ii) meets on a regular basis and forwards recommendations for initiatives to increase nurse retention to the nurse leadership; and

''(iii) works with the nurse leadership of the hospital to address and forward the recommendations under clause (ii) to the executive team of the hospital.

''(F) NURSE RESIDENCY TRAINING PROGRAM.—

''(i) IN GENERAL.—The hospital has developed a Nurse Residency Training Program (referred to in this section as the 'NRTP') for—

''(I) new graduate nurses entering the workforce on a full-time basis in a hospital setting; and

''(II) nurses returning to a hospital staff on a full-time basis after an absence of not less than 3 years without working in the nursing field.

''(ii) RETURNING NURSES.—The nurse leadership of the hospital evaluates the skills and competencies of each nurse described in clause (i)(II) to determine—

(I) whether that nurse needs to participate in the NRTP; and

(II) for how long that nurse should participate in the NRTP if it is determined under subclause (I) that the nurse needs to participate in the NRTP.

''(iii) TRAINING.—The—

''(I) hospital coordinates, to the greatest extent possible, the NRTP with an accredited school of nursing; or

''(II) NRTP is not less than 3 months and not more than 1 year in duration and accommodates sufficient training opportunities as determined by the nurse leadership in the facility.

''(G) CONTINUING EDUCATION.—The hospital promotes and, to the greatest extent possible, provides continuing education for the nursing staff—

''(i) to obtain nursing-related certification;

''(ii) to maintain continuing education units as required for nursing-licensure; and

''(iii) to further clinical skills through advanced training opportunities.

''(H) RECOGNITION AND REWARD PROGRAM.—The hospital has developed a recognition and reward program in conjunction with subparagraph (G) for a nurse who obtains a nursing-related certification from an accredited or professionally recognized organization that provides—

''(i) financial recognition and rewards; or

''(ii) non-financial recognition and rewards that are determined by the Nurse Retention Committee of the hospital to be appropriate.

''(d) ALLOCATION.—

''(1) IN GENERAL.—The Secretary shall determine the amount of a grant awarded to a hospital under this section on a case by case basis subject to paragraph (2).

''(2) MAXIMUM AMOUNTS.—The Secretary shall not award a grant exceeding—

''(A) $200,000 for a hospital with less than 100 staffed beds;

''(B) $400,000 for a hospital with less than 400 staffed beds; and

''(C) $600,000 for a hospital with 400 or more staffed beds.

''(e) RECEIPT OF FUNDS.—Not later than 60 days after awarding a grant to a hospital under subsection (a), the Secretary shall distribute the grant funds to the hospital.

''(f) USES OF FUNDS.—A grant awarded to a hospital under subsection (a) shall be used for 1 or more of the following:

''(1) Improvements to the work environment of the hospital for the nursing staff that improves the nursing staff's job satisfaction or safety, or both.

''(2) To provide continuing education programs for the nursing staff.

''(3) To continue the Nurse Residency Training Program.

''(4) To carry out initiatives recommended by the Nursing Retention Committee of the hospital to increase retention of the nursing staff.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $30,000,000 for each of fiscal years 2003 through 2005 and such sums as are necessary for each of fiscal years 2006 and 2007.

''SEC. 853. BRIDGE SCHOLARSHIP PROGRAM.

''(a) PROGRAM AUTHORIZED.—The Secretary shall establish a Bridge Scholarship Program (referred to in this section as the 'program') to provide scholarships to hospital-based professional nurses to enable such nurses to complete a Bachelor of Science in Nursing degree (referred to in this section as the 'degree') in exchange for service from such nurses in sponsoring hospitals upon completion of such degree.

''(b) ELIGIBILITY.—To be eligible to participate in the program an individual shall—

''(1) be employed by a hospital;

''(2) be accepted for enrollment, or be enrolled, in an accredited school of nursing;

''(3) submit the required materials in accordance with subsection (c)(2); and

''(4) be able to complete the degree not later than 3 years after enrolling in the accredited school of nursing.

''(c) APPLICATION PROCESS.—

''(1) DEVELOPMENT OF APPLICATION FORM.—The Secretary shall develop an application form that an individual shall use to apply for a scholarship under the program.

''(2) SUBMISSION.—Each individual desiring a scholarship under the program shall submit to the hospital where the individual is employed—

''(A) an official letter from each State licensing agency where the individual is licensed to practice nursing that the individual—

''(i) has an unrestricted license to practice nursing; and

''(ii) is in good standing;

''(B) an application for participation in the program;

''(C) proof of acceptance for enrollment, or enrollment in, an accredited school of nursing; and

''(D) a written contract accepting payment of a scholarship in exchange for providing the required service in the hospital where the individual is employed.

''(3) DUTY OF THE HOSPITAL.—A hospital that receives the materials described in paragraph (2) shall—

''(A) make a determination as to whether to enter into the contract under paragraph (2)(D) with the individual; and

''(B) if the hospital elects to enter into the contract with the individual, not later than May 31 of each calendar year, forward the materials it receives under paragraph (2) to the Division.

''(4) DUTIES OF THE DIVISION.—The Division shall—

''(A) review the materials forwarded under paragraph (3); and

''(B) not later than 30 days after receipt of the materials forwarded under paragraph (3), forward the materials to the Secretary with a recommendation as to whether the Secretary should award a scholarship to the applicant.

''(5) DUTIES OF THE SECRETARY.—Not later than 30 days after—

''(A) receipt of the materials forwarded under paragraph (4), the Secretary shall approve or disapprove the application submitted under paragraph (2); and

''(B) the Secretary approves or disapproves an application under subparagraph (A), the Secretary shall notify the applicant in writing of the approval or disapproval.

''(d) CONTRACT.—

''(1) IN GENERAL.—The Secretary shall develop a written contract for participation in the program.

''(2) CONTENT.—The contract described in paragraph (1) shall be an agreement between the Secretary, the individual, and the sponsoring hospital that states that, subject to paragraph (3)—

''(A) the Secretary agrees to—

''(i) provide the individual with a scholarship in each school year, not to exceed 3 years, in which the individual is pursuing the degree; and

''(ii) accept the individual into the program;

''(B) the individual agrees to—

''(i) accept any provision of such a scholarship;

''(ii) maintain enrollment in the accredited school of nursing until the individual completes the degree;

''(iii) while enrolled in the accredited school of nursing, maintain an acceptable level of academic standing; and

''(iv) work as a nurse at the sponsoring hospital upon completion of the degree for a period of 1 month for each month the individual was provided a scholarship under the program; and

''(C) the sponsoring hospital agrees to—

''(i) provide the option for the individual to work as a nurse while the individual is enrolled in the accredited school of nursing for any employment-shifts on which the individual and sponsoring hospital jointly agree (such work will not count towards the requirements of the individual to work at the sponsoring hospital under subparagraph (B)(iv)); and

''(ii) if the sponsoring hospital terminates the employment of the individual while the individual is working at the sponsoring hospital pursuant to subparagraph (B)(iv), submit to the Secretary a written explanation as to why the individual was terminated.

''(3) LIMITATION.—The contract described in paragraph (1) shall contain a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual and the sponsoring hospital which is conditioned thereon, is contingent upon funds being appropriated for scholarships under this section.

''(e) PAYMENT.—

''(1) IN GENERAL.—A scholarship provided to an individual under the program shall consist of payment to, or (in accordance with paragraph (2)) on behalf of, the individual of the amount of the tuition of the individual in such school year.

''(2) CONTRACT.—The Secretary may contract with an accredited school of nursing, in which an individual in the program is enrolled, for the payment to the accredited school of nursing of the amount of tuition described in paragraph (1).

''(f) BREACH OF AGREEMENT.—

''(1) INDIVIDUAL.—Subject to paragraph (3), if an individual participates in the program under this section and agrees to work as a nurse at the sponsoring hospital for a period of time in consideration for receipt of a scholarship to pursue a degree, the individual is liable to the Federal Government for the amount of such scholarship, and for interest on such amount at the maximum legal prevailing rate, if the individual—

''(A) fails to work as a nurse in accordance with subsection (d)(2)(B)(iv);

''(B) fails to maintain an acceptable level of academic standing in the degree program (as indicated by the accredited school of nursing in accordance with requirements established by the Secretary);

''(C) is dismissed from the degree program for disciplinary reasons; or

''(D) voluntarily terminates the degree program.

''(2) SPONSORING HOSPITAL.—If the sponsoring hospital fails to comply with subsection (d)(2)(C)(ii), the sponsoring hospital is liable to the Federal Government for the amount of the scholarship, and for interest on such amount at the maximum legal prevailing rate, of the individual whose employment was terminated.

''(3) WAIVER OR SUSPENSION OF LIABILITY.—The Secretary shall waive liability—

''(A) under paragraph (1) if compliance by the individual with the agreement involved is impossible due to a catastrophic life event of the individual; or

''(B) under paragraph (1)(A) if the sponsoring hospital terminates the employment of the individual.

''(g) REPORT.—

''(1) IN GENERAL.—Not later than 18 months after the first scholarship is awarded under this section, the Division shall submit to Congress a report evaluating the success of the program.

''(2) INFORMATION.—In order to prepare the report under paragraph (1), the Division shall maintain information about the scholarship recipients under this section, including—

''(A) grade reports from the accredited schools of nursing;

''(B) the degree graduation rate; and

''(C) the default rate on the contracts under the program.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $20,000,000 for each of fiscal years 2003 through 2005 and such sums as are necessary for each of fiscal years 2006 and 2007.''.

AMERICAN HOSPITAL ASSOCIATION,
Washington, DC, October 8, 2001.

Hon. JOSEPH LIEBERMAN,
U.S. Senate, Washington, DC.

DEAR SENATOR LIEBERMAN: The American Hospital Association (AHA) commends your efforts to address the nursing workforce shortage in your bill, The Hospital-Based Nursing Initiative Act of 2001, and is pleased to endorse your legislation. We believe your bill is an important component in the overall strategy of addressing the national nursing shortage.

The AHA represents nearly 5,000 hospitals, health systems, networks and other health care provider members.

Hospitals and health care facilities across America are experiencing a critical shortage of nurses. A recent AHA survey of the workforce shows that there are currently up to 126,000 Registered Nurses (RNs) needed by hospitals today. Over the past five years, enrollments in nursing programs have declined and this trend is expected to continue for the foreseeable future. The average age of a working RN is now over 43 years old, and is expected to continue to increase before peaking at age 45.5 in 2010, when many RNs will

begin to retire. And, the need for nurses will be further compounded by the potential health care demands of the looming 78 million aging ''baby boomers'' who will begin to retire over the next 10 years.

The current nursing shortage is creating an environment with the potential to jeopardize hospitals' ability to provide timely access to non-emergency, as well as emergency, services. An inadequate number and mix of personnel has caused some facilities to close beds, put emergency rooms on ''divert'' status, delay elective surgeries, and pare down hospital services.

Hospitals have enlisted many strategies and creative approaches to address the nursing shortage, but this is a complex problem that cannot be solved by hospitals alone. The role of the federal government is critical in the support and funding of an adequate nursing workforce.

''The Hospital-Based Nursing Initiative Act of 2001'' provides significant incentives for hospitals to examine and revise management principles to improve the quality of their work environment, and to foster effective RN retention programs. It establishes incentives for hospitals to develop and implement aggressive recruitment programs to attract nurses into the hospital setting. The legislation also creates bridge programs for RNs currently employed in hospitals to move up the career ladder, a significant recruitment and retention tool.

Helping alleviate the critical shortage of nurses is a priority for health care providers. As we debate this and other measures to address the nursing shortage, we hope Congress will recognize the important of investing in this critical area of need. We applaud your effort and pledge to work with you to address this very important issue.

Sincerely,

RICK POLLACK,
Executive Vice President.

AMERICAN ORGANIZATION OF NURSE EXECUTIVES,
Washington, DC, September 14, 2001.

Hon. JOSEPH I. LIEBERMAN,
U.S. Senate, Washington, DC.

DEAR SENATOR LIEBERMAN: On behalf of more than 3800 members of the American Organization of Nurse Executives (AONE) representing nurses in executive practice, I would like to express our strong support for the ''Hospital-Based Nursing Initiative Act of 2001,'' legislation that you have authored and plan to introduce to address the critical nurse shortage.

During the past year, AONE has played a pivotal role in addressing the nursing shortage. In October 2000 we published the first comprehensive monograph on this critical issue entitled Perspectives on the Nursing Shortage: A Blueprint for Action and have continued to provide both education and advocacy for the nursing profession on a number of different fronts. Your bill will provide important management incentives for hospitals to revise their management of nursing services in order to foster retention and promote recruitment of nurses back into the inpatient delivery system.

The majority of AONE's membership are leaders in the day-to-day management and delivery of direct patient care services, as a result, we understand firsthand the impacts and consequences of the growing nursing shortage both in this country and internationally. Our support of the ''Hospital-Based Nursing Initiative Act of 2001'' is based on the positive contributions that this legislation will make to nurse-directed efforts to foster retention and promote recruitment of nurses within the inpatient settings of our federal, community, and private hospitals. This legislation will also establish important bridge programs for registered nurses currently employed in hospitals to move from diploma and Associate Degree levels of education on to a Bachelor of Science degree within three years.

AONE applauds your efforts to address the nursing shortage through this innovative grant and scholarship program. We look forward to working with you to solve this critical health manpower problem.

Sincerely,

PAMELA A. THOMPSON, MSN, RN,
Executive Director.
DIANNE ANDERSON, MS, RN,
President.

AMERICAN NURSES ASSOCIATION,
Washington, DC, September 19, 2001.

Hon. JOSEPH LIEBERMAN,
U.S. Senate, Washington, DC.

DEAR SENATOR LIEBERMAN: I am writing you on behalf of the American Nurses Association (ANA) to express support for the Hospital-Based Nursing Initiative Act. We applaud your hard work on this important issue. ANA is the only full-service association representing the nation's registered nurses (RNs) through its 54 state and territorial member nurse associations. With more than 160,000 members, the ANA represents RNs in all practice settings throughout our nation.

ANA understands that a major contributing factor to the current and emerging nursing shortage is dissatisfaction with the work environment. The Congressional Research Service, General Accounting Office, academic research, and recent ANA surveys of American nurses have all revealed startling levels of frustration with working conditions. This dissatisfaction is leading experienced nurses to leave the bedside, and hindering recruitment efforts.

Fortunately, we know what can be done to address this growing problem. There are proven best practices for nursing that improve patient outcomes, and enhance nurse recruitment and retention. The American Nurses Credentialing Center, an ANA affiliate, recognizes facilities that have met these best practices by granting the 'Magnet' designation. Magnet facilities have consistently outperformed their peers in nursing services, even in times of national nursing shortages. In fact, average nurse retention in Magnet facilities is twice as long as that of non-Magnet institutions.

ANA is pleased to endorse your efforts to further the implementation of these best practices through the Hospital-Based Nursing Initiative Act. The quality of work environment and nurse retention grant program, and the continuing education scholarships contained in your bill will greatly aide in the adoption of Magnet criteria. ANA looks forward to working with you and your staff to support this legislation.

Sincerely,

ROSE GONZALEZ, MPS, RN,
Director, Government Affairs.

AMERICAN COLLEGE OF HEALTHCARE EXECUTIVES,
Chicago, IL, September 18, 2001.

Hon. JOSEPH I. LIEBERMAN,
U.S. Senate, Washington, DC.

DEAR SENATOR LIEBERMAN: Thank you for inviting the American College of Healthcare Executives to review and provide comments on the ''Hospital-Based Nursing Initiative Act of 2001.''

Upon reviewing the bill, ACHE wishes to endorse it. This legislation offers a comprehensive approach to the crisis facing our nation's healthcare system—a shortage of nurses. The bill attempts to address this important issue by supporting hospitals in a number of ways, including: retaining nurses; improving the work environment for nursing staff; fostering nursing leadership; providing continuing education programs for nurses; creating recognition and reward programs for nurses who obtain nursing-related certification; and finally, offering educational assistance for nurses to earn their Bachelor of Science Degree in Nursing. We believe this bill encompasses the various elements to make a genuine difference and increase the nursing population.

Thank you for your work in developing this legislation. If there is anything ACHE can do to assist further in this endeavor, please contact Susan M. Oster, CAE, Vice President, Administration at (312) 424–9340.

Sincerely,

THOMAS C. DOLAN, Ph.D., FACHE, CAE,
President and Chief Executive Officer.

PENNSYLVANIA STATE NURSES ASSOCIATION,
Harrisburg, PA, September 17, 2001.

Hon. JOSEPH LIEBERMAN,
U.S. Congress, Washington, DC.

DEAR SENATOR LIEBERMAN: The Pennsylvania State Nurses Association (PSNA) would like to commend you for the excellent legislation you plan to introduce, which is meant to establish grant and scholarship programs enabling hospitals to retain and further educate their nursing staffs. The bill contains excellent ideas and creative solutions to entice nurses to join or remain a member of a hospital nursing staff.

The focus on nurses having opportunities to participate in decision-making regarding nursing care and maintaining autonomy in the delivery of care are especially important attractants for nurses. Also, the emphasis on having a system for measuring outcomes is imperative for quality patient care.

The organization welcomes the opportunity to work with you in ensuring the passage of the legislation that will greatly benefit the profession of nursing and the quality of care provided to consumers.

Sincerely,

JESSIE F. ROHNER, DrPH, RN,
Interim Executive Administrator.

By Mr. KERRY (for himself, Mr. BREAUX, and Mr. HOLLINGS):

S. 1587. A bill to provide improved port and maritime security, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. BREAUX. Madam President, along with Mr. KERRY, Chairman of the Oceans, Atmosphere and Fisheries Subcommittee, and Mr. HOLLINGS, Chairman of the Commerce Committee, I rise today in support of the Port Threat and Security Act of 2001. I believe this legislation will help United States' authorities identify and counteract maritime threats from terrorist actions. Importantly, these provisions are designed in part to protect U.S. citizens and property from terrorist attacks before they reach our shores.

As Chairman of the Surface Transportation and Merchant Marine Subcommittee, I held several oversight hearings on transportation security, including one on maritime security three weeks after the terrible attacks of September 11. The maritime security hearing solidified an opinion that I, and others on the Commerce Committee, had long held, the need for increased maritime security was important before September 11, and is absolutely crucial following the terrorist

attacks on New York city and Washington, D.C. The Oceans, Atmosphere and Fisheries Subcommittee, of which I am a member, followed with another hearing that underscored this message. Luckily, because of the foresight of Chairman HOLLINGS, we had a head start on improving maritime security. S. 1214, the Maritime and Port Security Improvement Act, of which I am a proud cosponsor, was introduced in July and was reported out of the Committee in August. S. 1214 establishes a regime that will go a long way towards creating a safe and secure maritime transportation system. However, since much of it was crafted before September 11, it is only natural that additional measures are needed to ensure that our maritime system is as safe as possible.

The bill we are introducing today is based on the testimony that was presented at the hearings before the Commerce Committee in the first two weeks of October. Administration and industry witnesses testified on the need to improve certain areas of S. 1214. This bill intends to fill the gaps identified by our witnesses. We will work with Committee members to ensure these provisions are included in S. 1214 before the Senate sends it to the House.

A constant theme following the September 11 attacks has been the need for better information. Testimony at our hearings confirmed this theme in the maritime realm, we need to increase our information collection capabilities immediately and we need to hold our trading partners to the same standards to which we hold our maritime industry. This legislation requires the identification of nations that have inherently insecure or unsafe vessel registration procedures that can pose threats to our national security. It requires the Secretary of Transportation and Secretary of State to prepare an annual report for the Congress that would list those nations whose vessels the Coast Guard has found don't play by our rules. For example, investigations by the Department of Transportation reveal that it is common practice for vessels to possess false, partial, or fraudulent information concerning cargo manifests, crew identity, or registration of the vessel. This legislation will allow us to get a handle on these practices by identifying the most egregious violators of maritime law. However, the additional information collection required by this bill is just a start; the bill also requires the Administration to recommend to this Committee additional actions that can be taken, either domestically or through international organizations such as the International Maritime Organization, that will increase the transparency of vessel registration procedures.

One of the responses following the highjackings has been to dramatically expand the air marshal program on air carriers, a step which I fully support. However, there is no similar program for maritime vessels in U.S. waters. The Coast Guard recently established a sea marshal program in the port of San Francisco where armed personnel accompany maritime pilots aboard vessels that cause security concerns. This legislation expands that small project into a national sea marshal program to help prevent terrorists from using maritime vessels as weapons of mass destruction. This legislation directs the Secretary to analyze vulnerability of ports and place sea marshals in ports that handle materials or vessels that make them potential targets of attack.

Expansion of the sea marshal program is strongly supported by our Nation's sea pilots. Many people do not know that almost all maritime vessels that enter U.S. ports are accompanied by a U.S. sea pilot that has intimate knowledge of port and navigational channels, a living nautical chart, so to speak. They are an integral part of our maritime system that help to keep our ports and waterways safe. Pilots are often the first U.S. citizen to board inbound foreign vessels and may be the only U.S. citizens on vessels bound for U.S. ports; thus, they can be a valuable source of information. This legislation requires the Secretary of Transportation to use them more effectively in the war on terror. The Secretary is directed to investigate secure and reliable methods in which sea pilots can aid the Coast Guard and other U.S. authorities in an expanded maritime domain awareness program. The pilots themselves came forward to this Committee suggesting this idea, and I think it is critical that these pilots be provided with methods and equipment that will allow them to safely provide the authorities with information on illegal or terrorist activities while there is still time to prevent a catastrophe. One such example is the Vessel Traffic System, VTS, in the Port of New Orleans and the excellent partnership between the Coast Guard and the Crescent River Pilots Association. Under this partnership, vessels entering port are boarded by pilots carrying transponders. As the vessel transits the Mississippi River, inbound and outbound, the operations center manned by Coast Guard and pilots know the exact position of the vessel, as well as the course, speed and other important information. While already considered a model VTS program, once additional transponders are acquired, this program will continue to serve as a template for other ports.

This legislation also greatly improves the information collected on the safety and security of foreign ports. With regards to foreign seaport assessments, the bill aligns the authority of the Secretary of Transportation with authorities that currently exist for foreign airports. The Secretary of Transportation is required to conduct 25 foreign port vulnerability assessments each year and to ensure that U.S. citizens are informed about the results of these assessments in advance of embarking on their travel plans. Testimony before the Commerce Committee emphasized that in order to ensure that our shores are as safe as possible, we must view foreign ports as the outer boundary of our ''maritime domain.'' Much as the first provision in our bill provides for the collection of better information on vessels and countries that do not follow international standards, this provision provides for the collection of information on foreign ports that present potential security threats to the United States. By requiring the Secretary to conduct annual assessments of 25 ports, we not only gain a valuable source of information, but we also put foreign ports on notice that they will be held responsible for actions to secure their ports.

If the assessments reveal that foreign ports do not have or maintain adequate security measures, the President is authorized to prohibit any vessel, U.S. flagged or foreign, from entering the United States from that port. Vessels that transit unsafe and insecure ports should not be allowed unrestricted access to United States ports. I would like to remind everyone that similar security protections were enacted for foreign airports, and I see no reason why the President should not have the same powers with respect to foreign maritime ports.

We must begin to think of a maritime security program that begins well before a ship enters U.S. waters and certainly before they enter U.S. ports. I believe that the measures in this bill along with the port security program of S. 1214 will provide much better tools to guard against maritime threats to our Nation and our citizens.

Mr. KERRY. Madam President, As Chairman of the Oceans, Atmosphere and Fisheries Subcommittee, I rise today to introduce legislation to identify and reduce maritime threats from criminal or terrorist action, particularly those originating from foreign ports and vessels. I am particularly pleased to be joined by the Chairman of the Commerce Committee Mr. HOLLINGS of South Carolina and the Chairman of the Surface Transportation and Merchant Marine Subcommittee Mr. BREAUX of Louisiana.

Senator BREAUX and I recently held oversight hearings before our respective Subcommittees on the Coast Guard and its role in improving maritime security after the terrible attacks of September 11. As Senators HOLLINGS and BREAUX well know, even before September 11 our maritime and port security was in sorry shape. Senator HOLLINGS had already recognized the need to rectify these deficiencies and authored S. 1214, the Maritime and Port Security Improvement Act, which was reported out of the Committee in August, and which I am proud to cosponsor. However, the attacks on New York and Washington made it clear we need to go farther afield to guard against terrorism and other crimes.

Today's legislation is intended to supplement the security provisions of

S. 1214 by improving our ability to detect and prevent maritime terrorism and crime before it has the chance to sail into U.S. ports. We intend to work with Committee members to ensure these provisions are included in the final bill the Senate sends to the House.

At our October 11 oversight hearing, Coast Guard Commandant James Loy and other witnesses gave some thoughtful testimony that is the backbone of this legislation. The hearing also brought to light the challenges presented to the Coast Guard in securing our maritime border from such threats. In addition to introducing this legislation, we also will address glaring Coast Guard resource shortfalls through increased authorizations in our FY 2002 Coast Guard authorization bill, which we will bring to the floor shortly. The Port Threat and Security Act is focused on giving the Coast Guard the tools and the information they need to do the job right.

First, we need to improve our base of information to identify bad actors throughout the maritime realm. This legislation would help us identify those nations whose vessels and vessel registration procedures pose potential threats to our national security. It would require the Secretaries of Transportation and State to prepare an annual report for the Congress that would list those nations whose vessels the Coast Guard has found would pose a risk to our ports, or that have presented our government with false, partial, or fraudulent information concerning cargo manifests, crew identity, or registration of the vessel. In addition the report would identify nations that do not exercise adequate control over their vessel registration and ownership procedures, particularly with respect to security issues. We need hard information like this if we are to force ''flag of convenience'' nations from providing cover to criminals and terrorists. Mr. President, this is very important as Osama bin Laden has used flags of convenience to hide his ownership in various international shipping interests. In 1998 one of bin Laden's cargo freighters unloaded supplies in Kenya for the suicide bombers who later destroyed the embassies in Kenya and Tanzania. To that end, the bill requires the Administration to report on actions they have taken, or would recommend, to close these loopholes and improve transparency and registration procedures, either through domestic or international action—including action at the International Maritime Organization.

My legislation would also establish a national Sea Marshal program to protect our ports from the potential use of vessels as weapons of terror. A Sea Marshal program was recently established in San Francisco, and is supported strongly by the maritime pilots who, like airline pilots, are on the front lines in bringing vessels into U.S. ports. Sea Marshals would be used in ports that handle materials that are hazardous or flammable in quantities that make them potential targets of attack. The Coast Guard took a number of steps including using armed Coast Guard personnel to escort a Liquid Natural Gas, LNG, tanker into Boston last evening. This was the first delivery of LNG to Boston since September 11 and a number of people were concerned about the safety of bringing LNG into the port. Prior to September 11 these vessels were escorted by Coast Guard vessels into the port but no armed guards were present on the vessel. I strongly believe that having armed personnel, such as Sea Marshals, on these high interest vessels is very important and will considerably increase security in our nation's ports, including Boston. The ability of terrorists to board a vessel and cause a deliberate release of LNG or gasoline for that matter is very real. Sea Marshals will make it much more difficult for this to happen. The Secretary of Transportation would be responsible for establishing qualifications and standards for Sea Marshals which could be comprised of Federal, State or local law enforcement officials.

This legislation also aims to make use of unarmed pilots as yet another way to combat terrorism in our ports. Nearly every vessel that enters a U.S. port is first boarded by a sea pilot to assist the crew in navigating the harbor. Many times these pilots are the first set of U.S. eyes on vessels that may be headed to our ports bearing criminals or contraband from overseas. They are our eyes and ears, but cannot be expected to be a line of physical defense, that is the job of the Sea Marshals. This legislation would require the Secretary of Transportation to use these ''eyes and ears'' effectively in the war on terror. The Secretary is directed to investigate discrete ways in which sea pilots can provide information to warn of a possible terrorist attack or other crime. It is important that we explore secure mechanisms to allow these pilots to contribute to our maritime domain awareness, including notifying law enforcement officials of suspicious activity on a vessel. I am convinced there are a number of ways that these pilots could safely provide the authorities with information that can thwart illegal activities without alerting the vessel's captain or crew, or potential terrorists.

This legislation would also require the Secretary of Transportation to conduct 25 foreign port vulnerability assessments each year, and places on foreign ports the same reporting and assessment requirements we use for foreign airports. This is essential to ensure that U.S. citizens are protected from harm in foreign ports, and are informed about any risks before leaving U.S. soil. It is also absolutely necessary to use foreign ports as our first defense against threats to U.S. ports. We cannot expect to protect U.S. borders by erecting a fence only at our own ports. As one of our witnesses said, ''the leading edge of our boundary for homeland defense is, in fact, foreign ports.'' In many instances, such defenses would be fruitless because of the sheer volume of cargo that passes through our ports daily. We need advance warning long before these vessels appear at our harbor entrances. Critical information that can help the Coast Guard identify these risks can only be collected at foreign ports where cargo and persons are first placed aboard the vessel. Despite this obvious need, we have fallen behind on our assessments of foreign ports. I firmly believe that the only way we can make U.S. ports and harbors safe is by going to the source and ensuring appropriate measures and facilities are in place to guarantee the safety of U.S. citizens visiting foreign ports as well as the safety of cargo bound for the United States.

In order to pay for these inspections this legislation authorizes the Secretary of Transportation to collect a 50 cent user fee on all cruise passengers that depart the United States for a foreign port. Quite frankly, 50 cents is a small price to pay for the peace of mind that comes with knowing that a port vulnerability assessment has been completed prior to a cruise ship with as many as 5,000 U.S. citizens as passengers, docks in a particular country. U.S. citizens should not be disembarking in ports that have not been scrutinized for security violations. One witness pointed out that in many circumstances U.S. cruise ship passengers are passing through ports that could not be assessed because they were deemed too dangerous for military personnel! This is ludicrous. I am sure those passengers had no idea of this potential danger, and we need to make sure that they are both safe and informed.

Lastly, this legislation would allow the President to prohibit any vessel, U.S. flagged or foreign, from entering the United States if the vessel has embarked passengers or cargo from foreign ports that do not have adequate security measures as determined by the Secretary of Transportation. Recently inspectors in Italy checking a container bound for Canada discovered a member of the al-Qaida terrorist organization hiding in a shipping container equipped with a bed and makeshift bathroom. The suspect, an Egyptian in a business suit, had with him a Canadian passport, a laptop computer, two cell phones, airport maps, security passes for airports in three countries and a certificate proclaiming him an airplane mechanic. We cannot allow any country to have such poor security such that terrorists can stow away in a shipping container. I would like to remind everyone that a similar provision exists in the airline industry and I see no reason why the President should not have the power to suspend commerce from a port with inadequate security, just like he can now do with international airports.

I believe that these provisions, when combined with the strong port security program of S. 1214, will ensure that the United States has the tools, the information, and the personnel to guard against waterborne threats to our nation and our citizens.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1587

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Port Threat and Security Act''.

SEC. 2. IMPROVED REPORTING ON FOREIGN-FLAG VESSELS ENTERING UNITED STATES PORTS.

Within 6 months after the date of enactment of this Act and every year thereafter, the Secretary of Transportation, in consultation with the Secretary of State, shall provide a report to the Committees on Commerce, Science, and Transportation and Foreign Relations of the Senate, and the Committees on Transportation and Infrastructure and International Relations of the House of Representatives that lists the following information:

(1) A list of all nations whose flag vessels have entered United States ports in the previous year.

(2) Of the nations on that list, a separate list of those nations—

(A) whose registered flag vessels appear as Priority III or higher on the Boarding Priority Matrix maintained by the Coast Guard;

(B) that have presented, or whose flag vessels have presented, false, intentionally incomplete, or fraudulent information to the United States concerning passenger or cargo manifests, crew identity or qualifications, or registration or classification of their flag vessels;

(C) whose vessel registration or classification procedures have been found by the Secretary to be insufficient or do not exercise adequate control over safety and security concerns; or

(D) whose laws or regulations are not sufficient to allow tracking of ownership and registration histories of registered flag vessels.

(3) Actions taken by the United States, whether through domestic action or international negotiation, including agreements at the International Maritime Organization under section 902 of the International Maritime and Port Security Act (46 U.S.C. App. 1801), to improve transparency and security of vessel registration procedures in nations on the list under paragraph (2).

(4) Recommendations for legislative or other actions needed to improve security of United States ports against potential threats posed by flag vessels of nations named in paragraph (2).

SEC. 3. SEA MARSHAL PROGRAM.

(a) ESTABLISHMENT.—Within 6 months after the date of enactment of this Act, the Secretary of Transportation shall establish a program to place sea marshals on vessels entering United States Ports identified in subsection (c).

(b) CONSULTATION.—In establishing this program, the Secretary shall consult with representatives from the port security task force and local port security committees.

(c) SEA MARSHAL PORTS.—The Secretary shall identify United States ports for inclusion in the sea marshal program based on criteria that include the following:

(1) The presence of port facilities that handle materials that are hazardous or flammable in quantities that make them potential targets of attack.

(2) The proximity of these facilities to residential or other densely populated areas.

(3) The proximity of sea lanes or navigational channels to hazardous areas that would pose a danger to citizens in the event of a loss of navigational control by the ship's master.

(4) Any other criterion deemed necessary by the Secretary.

(d) SEA MARSHAL QUALIFICATIONS.—The Secretary shall establish appropriate qualifications or standards for sea marshals. The Secretary may use, or require use of, Federal, State, or local personnel as sea marshals.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Transportation such sums as may be necessary to carry out the requirements of this section for each of the fiscal years 2002 through 2006.

(f) REPORT.—Within 3 years after the date of enactment of this Act, the Secretary shall report to the Committee on Commerce, Science, and Transportation of the Senate, and Committee on Transportation and Infrastructure of the House of Representatives on the success of the program in protecting the ports listed under (c), and submit any recommendations.

SEC. 4. SEA PILOT COMMUNICATION AND WARNING SYSTEM.

Within 6 months after the date of enactment of this Act, the Secretary of Transportation shall provide a secure report to the Committee on Commerce, Science, and Transportation of the Senate, and Committee on Transportation and Infrastructure of the House of Representatives on the potential for increasing the capabilities of sea pilots to provide information on maritime domain awareness. The report should specifically address necessary improvements to both reporting procedures and equipment that could allow pilots to be integrated more effectively in an maritime domain awareness program.

SEC. 5. SECURITY STANDARDS AT FOREIGN SEAPORTS.

(a) ASSESSMENT.—

(1) IN GENERAL.—The Secretary shall assess the effectiveness of the security measures maintained at—

(A) each foreign seaport—

(i) served by United States vessels;

(ii) from which foreign vessels serve the United States; or

(iii) that poses a high risk of introducing danger to international sea travel; and

(B) other foreign seaports the Secretary considers appropriate.

(2) INTERNATIONAL COOPERATION AND STANDARDS.—The Secretary of Transportation shall conduct an assessment under paragraph (1) of this subsection—

(A) in consultation with appropriate port authorities of the government of a foreign country concerned and United States vessel operators serving the foreign seaport for which the Secretary is conducting the assessment;

(B) to establish the extent to which a foreign seaport effectively maintains and carries out security measures; and

(C) by using a standard that will result in an analysis of the security measures at the seaport based at least on the standards and recommended practices of the International Maritime Organization in effect on the date of the assessment.

(3) REPORT.—Each report to Congress required under section 2 shall contain a summary of the assessments conducted under this subsection.

(b) INTERVAL.—The Secretary of Transportation shall conduct assessments under subsection (a) of this section of at least 25 foreign seaports annually until all seaports identified in subsection (a)(1) are completed. The first 25 of these assessments shall be conducted within 18 months after the date of enactment of this Act.

(c) CONSULTATION.—In carrying out subsection (a) of this section, the Secretary of Transportation shall consult with the Secretary of State—

(1) on the terrorist threat that exists in each country; and

(2) to establish which foreign seaports are not under the de facto control of the government of the foreign country in which they are located and pose a high risk of introducing danger to international sea travel.

(d) QUALIFIED ASSESSMENT ENTITIES.—In carrying out subsection (a) of this section, the Secretary of Transportation may utilize entities determined by the Secretary of Transportation and the Secretary of State to be qualified to conduct such assessments.

(e) NOTIFYING FOREIGN AUTHORITIES.—If the Secretary of Transportation, after conducting an assessment under subsection (a) of this section, determines that a seaport does not maintain and carry out effective security measures, the Secretary, after advising the Secretary of State, shall notify the appropriate authorities of the government of the foreign country of the decision and recommend the steps necessary to bring the security measures in use at the seaport up to the standard used by the Secretary in making the assessment.

(f) ACTIONS WHEN SEAPORTS NOT MAINTAINING AND CARRYING OUT EFFECTIVE SECURITY MEASURES.—

(1) IN GENERAL.—If the Secretary of Transportation makes a determination under subsection (e) that a seaport does not maintain and carry out effective security measures, the Secretary—

(A) shall publish the identity of the seaport in the Federal Register;

(B) shall require the identity of the seaport to be posted and displayed prominently at all United States seaports at which scheduled passenger carriage is provided regularly;

(C) shall notify the news media of the identity of the seaport;

(D) shall require each United States and foreign vessel providing transportation between the United States and the seaport to provide written notice of the decision, on or with the ticket, to each passenger buying a ticket for transportation between the United States and the seaport; and

(E) may, after consulting with the appropriate port authorities of the foreign country concerned and United States and foreign vessel operators serving the seaport and with the approval of the Secretary of State, withhold, revoke, or prescribe conditions on the operating authority of a United States or foreign vessel that uses that seaport to provide foreign sea transportation.

(2) PRESIDENTIAL ACTION.—If the Secretary makes such a determination under subsection (e) about a seaport, the President may prohibit a United States or foreign vessel from providing transportation between the United States and any other foreign seaport that is served by vessels navigating to or from the seaport with respect to which a decision is made under this section.

(3) WHEN ACTION TO BE TAKEN.—

(A) IN GENERAL.—The provisions of paragraphs (1) and (2) shall apply with respect to a foreign seaport—

(i) 90 days after the government of a foreign country is notified of the Secretary's determination under subsection (e) of this section unless the Secretary of Transportation finds that the government has

brought the security measures at the seaport up to the standard the Secretary used in making an assessment under subsection (a) of this section before the end of that 90-day period; or

(ii) on the date on which the Secretary makes that determination if the Secretary of Transportation determines, after consulting with the Secretary of State, that a condition exists that threatens the safety or security of passengers, vessels, or crew traveling to or from the seaport.

(B) TRAVEL ADVISORY NOTIFICATION.—The Secretary of Transportation immediately shall notify the Secretary of State of a determination under subparagraph (A)(ii) of this paragraph so that the Secretary of State may issue a travel advisory required under section 908 of the International Maritime and Port Security Act (46 U.S.C. App. 1804).

(4) CONGRESSIONAL NOTIFICATION.—The Secretary of Transportation promptly shall submit to Congress a report (and classified annex if necessary) on action taken under paragraph (1) or (2) of this subsection, including information on attempts made to obtain the cooperation of the government of a foreign country in meeting the standard the Secretary used in assessing the seaport under subsection (a) of this section.

(5) CANCELLATION OF PUBLICATION REQUIREMENTS.—If the Secretary of Transportation, in consultation with the Secretary of State, determines that effective security measures are maintained and carried out at the seaport against which the Secretary took action under paragraph (1), then the Secretary shall—

(A) terminate action under paragraph (1) against that seaport; and

(B) notify the Congress of the Secretary's determination.

(g) SUSPENSIONS.—The Secretary of Transportation, with the approval of the Secretary of State and without notice or a hearing, shall suspend the right of any United States vessel to provide foreign sea transportation, and the right of a person to operate vessels in foreign sea commerce, to or from a foreign seaport if the Secretary of Transportation determines that—

(1) a condition exists that threatens the safety or security of passengers, vessels, or crew traveling to or from that seaport; and

(2) the public interest requires an immediate suspension of transportation between the United States and that seaport.

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Transportation $2,000,000 for fiscal year 2002 and each fiscal year thereafter to carry out this section.

SEC. 6. FOREIGN PORT ASSESSMENT FEES.

(a) IN GENERAL.—The Secretary of Transportation shall collect a user fee from cruise vessel lines upon the arrival of a cruise vessel at a United States port from a foreign port. Amounts collected under this section shall be treated as offsetting collections to offset annual appropriations for the costs of providing foreign port vulnerability assessments under section 5.

(b) AMOUNT OF FEE.—Cruise vessel lines shall remit $0.50 for each passenger embarkment on a cruise that includes at least one United States port and one foreign port.

(c) USE OF FEES.—A fee collected under this section shall be used solely for the costs associated with providing foreign port vulnerability assessments and may be used only to the extent provided in advance in an appropriation law.

(d) EFFECTIVE DATE.—The requirements of this section apply with respect to travel beginning more than 179 days after the date of enactment of this Act.

By Mr. CRAIG (for himself, Mr. DORGAN, Mr. GRASSLEY, Mr. BAUCUS, Mr. CRAPO, Mr. BAYH, Mr. BENNETT, Mr. CARPER, Ms. COLLINS, Mr. ENSIGN, Mr. HOLLINGS, Mr. HUTCHINSON, Mr. INHOFE, Mr. KYL, Mrs. LINCOLN, Mr. MURKOWSKI, Mrs. MURRAY, and Mr. SMITH of Oregon):

S. 1588. A bill to provide a 1-year extension of the date for compliance by certain covered entities with the administrative simplification standards for electronic transactions and code sets issued in accordance with the Health Insurance Portability and Accountability Act of 1996; to the Committee on Finance.

Mr. CRAIG. Mr. President, I am happy to join Senator DORGAN in reintroducing legislation regarding the administrative simplification provision of the Health Insurance Portability and Accountability Act. We originally introduced legislation five months ago and have worked since then with members from both the Finance and HELP committees to negotiate a compromise. The bill we are introducing today is the product of those discussions. It provides for one additional much-needed year for providers, State health programs, health plans and others to implement the transactions and code set provision of administrative simplification. Importantly, this new version also includes language to clearly differentiate between this provision and the privacy provision of HIPAA. It was our intention all along that the medical privacy regulations not be affected by our legislation, and we believe this bill accomplishes that goal. My colleague and I have the benefit of being joined on this bill by many of the cosponsors of the original bill, and we are happy to have their support.

Mr. DORGAN. Mr. President, Like Senator CRAIG, I appreciate the cooperation of our colleagues in helping us to work through this issue. We have arrived at a solution that is agreeable to the majority of parties involved, while at the same time reaching our goal of providing relief to small providers and plans and public health programs that are struggling to prepare their systems for this cost. Senator CRAIG and I would have preferred that this bill go further in providing more time and coordination for affected entities. On the other hand, we acknowledge that others would prefer no action in this area. Since we are just one year from the scheduled compliance date, however, we recognize that all those affected need some certainty as they move forward with complying with the transactions and code sets regulation. Given that this bill does provide needed relief for our states and given the time constraints we are facing, we believe this compromise is appropriate and do not feel an additional extension can be acquired.

By Mr. ROCKEFELLER (for himself, Mr. WELLSTONE, and Mr. BAUCUS):

S. 1589. A bill to amend title XVIII of the Social Security Act to expand medicare benefits to prevent, delay, and minimize the progression of chronic conditions, establish payment incentives for furnishing quality services to people with serious and disabling chronic conditions, and develop national policies on effective chronic condition care, and for other purposes; to the Committee on Finance.

Mr. ROCKEFELLER. Madam President, I join several colleagues today to introduce the Medicare Chronic Care Improvement Act of 2001. Although we in Congress are focused on helping the Nation recover from the horrific attacks of September 11, we must also stand tall against the terrorists who wish to sabotage our domestic policy agenda and continue to work on the issues that affect the everyday health and well being of American citizens. With this conviction, I believe it is time to address the leading health care problem of the 21st century, chronic conditions.

Chronic conditions account for an astounding 90 percent of morbidity, 80 percent of deaths, and over 75 percent of direct medical expenditures in the United States. Nearly 125 million Americans have chronic conditions, and this number is expected to increase to 157 million, approximately half the population, by 2020.

Chronic conditions encompass an array of health conditions that are persistent, recurring, and cannot be cured. They include severely impairing conditions like Alzheimer's disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, depression, hypertension, and arthritis. Certainly in West Virginia, many of our workers, especially coal miners and steelworkers, suffer from chronic conditions.

Treating serious and disabling chronic conditions is the highest cost and fastest growing segment of health care. Direct medical costs for chronic conditions reached $510 billion in 2000 and are projected to reach $1.07 trillion by 2020.

An estimated 80 percent of Medicare beneficiaries suffer from at least one chronic condition and those beneficiaries account for an astounding 95 percent of Medicare spending. But Medicare does not provide many of the health care services that people with chronic conditions need. For example, current Medicare data show that, on average, people with chronic conditions see eight different physicians. Medicare does not compensate these physicians for communicating with one another, nor are they paid for care coordination, monitoring medications, early detection, or for educating or counseling patients and caregivers. As a result, few of these services, which are critical to people with chronic conditions, are provided.

To meet the needs of these individuals, our health care system must embrace a person-centered, system-oriented approach to care. Payers and providers who serve the same person

must be empowered to work together to help people with chronic conditions prevent, delay, or minimize disease and disability progression and maximize their health and well being.

Over 10 years ago, I served as Chairman of the Pepper Commission. Our final report recognized that people with chronic conditions have special needs requiring multidisciplinary health care or social services to compliment or augment their health care. The Commission further recognized that medical care cannot be fully accessible or effective for this segment of the population unless it is accompanied by education, outreach, and systems to coordinate a broad range of services. The Commission identified these needed changes over ten years ago. And, as I stand before you today, not a single one of these recommendations has been made.

I am here to propose a long overdue and much needed solution, The Medicare Chronic Care Improvement Act of 2001. This bill establishes a comprehensive plan to update and streamline the Medicare healthcare delivery system to better meet the needs of people with chronic health conditions.

First, the Medicare Chronic Care Improvement Act of 2001 helps prevent, delay, and minimize the progression of chronic conditions by authorizing the Secretary of Health and Human Services to expand coverage of preventive health benefits. The bill permits providers to waive deductibles and co-payments for preventive and wellness services and streamlines the process of approving preventive benefits.

Second, this bill provides a person-centered, system-oriented approach to care for this extremely vulnerable segment of our population by expanding Medicare coverage to include assessment, care-coordination, self-management services, and patient and family caregiver education and counseling.

Third, this legislation improves Medicare fee-for-service and managed care financing for plans that serve beneficiaries with multiple, complex chronic conditions. The Secretary is directed to develop a plan to refine payment incentives to ensure appropriate payment for serving these high-cost individuals.

And finally, the Medicare Chronic Care Improvement Act of 2001 requires the Secretary of HHS to report to Congress on chronic condition trends and costs as a foundation for establishing national chronic care policies.

For more detail, I am also entering a section-by-section bill summary into the CONGRESSIONAL RECORD following this statement.

This legislation has been endorsed by a variety of health organizations representing consumers and providers including:

Chronic Care Coalition, comprising the American Association of Homes and Services for the Aging, American Geriatrics Society, Catholic Health Association of the United States, Elderplan Social HMO, National Chronic Care Consortium, National Council on the Aging, and National Family Caregivers Association;

National Depressive and Manic-Depressive Association;

Association for Ambulatory Behavioral Healthcare; American Lung Association; American Academy of Neurology; American Neurological Association; and United Seniors Health Cooperative.

The Medicare Chronic Care Improvement Act of 2001 provides a comprehensive solution to improving the quality of life and health for millions of Americans who are struggling with serious and disabling chronic conditions. It improves benefits for people with chronic conditions, it empowers providers to better care for these people, and it provides us with the research we need to better address chronic conditions in the future.

And last, but not least, this legislation has the potential to save the Medicare program money, by better managing and treating chronic conditions before costly complications result. That is good for seniors and good for Medicare, a win-win situation. It is time to step up to the plate and fulfill our obligation to our Nation's most vulnerable citizens. This bill should stimulate the debate, and when Congress returns to business not related to the September 11th attacks, I intend to advance this legislation in the Finance Committee.

I ask unanimous consent that the text of the bill and the summary be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

S. 1589

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Chronic Care Improvement Act of 2001''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. DEFINITIONS.

In this Act:

(1) SECRETARY.—Unless otherwise specifically provided, the term ''Secretary'' means the Secretary of Health and Human Services.

(2) SERIOUS AND DISABLING CHRONIC CONDITION.—The term ''serious and disabling chronic condition'' means, with respect to an individual, that the individual has at least one physical or mental condition and a licensed health care practitioner has certified within the preceding 12-month period that—

(A) the individual has a level of disability such that the individual is unable to perform (without substantial assistance from another individual) for a period of at least 90 days due to a loss of functional capacity—

(i) at least 2 activities of daily living; or

(ii) such number of instrumental activities of daily living that is equivalent (as determined by the Secretary) to the level of disability described in clause (i);

(B) the individual has a level of disability equivalent (as determined by the Secretary) to the level of disability described in subparagraph (A); or

(C) the individual requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

(3) ACTIVITIES OF DAILY LIVING.—The term ''activities of daily living'' means each of the following:

(A) Eating.
(B) Toileting.
(C) Transferring.
(D) Bathing.
(E) Dressing.
(F) Continence.

(4) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term ''instrumental activities of daily living'' means each of the following:

(A) Medication management.
(B) Meal preparation.
(C) Shopping.
(D) Housekeeping.
(E) Laundry.
(F) Money management.
(G) Telephone use.
(H) Transportation use.

TITLE I—EXPANSION OF BENEFITS TO PREVENT, DELAY, AND MINIMIZE THE PROGRESSION OF CHRONIC CONDITIONS.

Subtitle A—Improving Access to Preventive Services

SEC. 101. DEFINITIONS.

In this title:

(1) COST-EFFECTIVE BENEFIT.—The term ''cost-effective benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

(C) demonstrated value as measured by unit costs relative to health outcomes achieved.

(2) COST-SAVING BENEFIT.—The term ''cost-saving benefit'' means a benefit or technique that has—

(A) been subject to peer review;

(B) been described in scientific journals; and

(C) caused a net reduction in health care costs for medicare beneficiaries.

(3) MEDICALLY EFFECTIVE.—The term ''medically effective'' means, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

(C) determined to achieve an intended goal under normal programmatic conditions.

(4) MEDICALLY EFFICACIOUS.—The term ''medically efficacious'' means, with respect to a benefit or technique, that the benefit or technique has been—

(A) subject to peer review;

(B) described in scientific journals; and

(C) determined to achieve an intended goal under controlled conditions.

SEC. 102. ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR EXISTING PREVENTIVE HEALTH BENEFITS.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by inserting after subsection (o) the following new subsection:

''(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR PREVENTIVE HEALTH ITEMS AND SERVICES.—The Secretary shall not require the payment of any deductible or coinsurance under subsection (a) or (b), respectively, of any individual enrolled for coverage under this part for any of the following preventive health items and services:

''(1) Blood-testing strips, lancets, and blood glucose monitors for individuals with diabetes described in section 1861(n).

''(2) Diabetes outpatient self-management training services (as defined in section 1861(qq)(1)).

''(3) Pneumococcal, influenza, and hepatitis B vaccines and administration described in section 1861(s)(10).

''(4) Screening mammography (as defined in section 1861(jj)).

''(5) Screening pap smear and screening pelvic exam (as defined in paragraphs (1) and (2) of section 1861(nn), respectively).

''(6) Bone mass measurement (as defined in section 1861(rr)(1)).

''(7) Prostate cancer screening test (as defined in section 1861(oo)(1)).

''(8) Colorectal cancer screening test (as defined in section 1861(pp)(1)).

''(9) Screening for glaucoma (as defined in section 1861(uu)).

''(10) Medical nutrition therapy services (as defined in section 1861(vv)(1)).''.

(b) WAIVER OF COINSURANCE.—

(1) IN GENERAL.—Section 1833(a)(1)(B) of the Social Security Act (42 U.S.C. 1395l(a)(1)(B)) is amended to read as follows: ''(B) with respect to preventive health items and services described in subsection (p), the amounts paid shall be 100 percent of the fee schedule or other basis of payment under this title for the particular item or service,''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after ''1861(s)(10)(A)'' the following: '', preventive health items and services described in section 1833(p),''.

(c) WAIVER OF APPLICATION OF DEDUCTIBLE.—Section 1833(b)(1) of the Social Security Act (42 U.S.C. 1395l(b)(1)) is amended to read as follows: ''(1) such deductible shall not apply with respect to preventive health items and services described in subsection (p),''.

(d) ADDING ''LANCET'' TO DEFINITION OF DME.—Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by striking ''blood-testing strips and blood glucose monitors'' and inserting ''blood-testing strips, lancets, and blood glucose monitors''.

(e) CONFORMING AMENDMENTS.—

(1) ELIMINATION OF COINSURANCE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)), as amended by section 201(b)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–481), as enacted into law by section 1(a)(6) of Public Law 106–554, are each amended by inserting ''or which are described in subsection (p)'' after ''assignment-related basis''.

(2) ELIMINATION OF COINSURANCE FOR CERTAIN DME.—Section 1834(a)(1)(A) of the Social Security Act (42 U.S.C. 1395m(a)(1)(A)) is amended by inserting ''(or 100 percent, in the case of such an item described in section 1833(p))'' after ''80 percent''.

(3) ELIMINATION OF DEDUCTIBLES AND COINSURANCE FOR COLORECTAL CANCER SCREENING TESTS.—Section 1834(d) of the Social Security Act (42 U.S.C. 1395m(d)) is amended—

(A) in paragraph (2)(C)—

(i) by striking ''(C) FACILITY PAYMENT LIMIT.—'' and all that follows through ''Notwithstanding subsections'' and inserting the following:

''(C) FACILITY PAYMENT LIMIT.—Notwithstanding subsections'';

(ii) by striking ''(I) in accordance'' and inserting the following:

''(i) in accordance'';

(iii) by striking ''(II) are performed'' and all that follows through ''payment under'' and inserting the following:

''(ii) are performed in an ambulatory surgical center or hospital outpatient department,

payment under''; and

(iv) by striking clause (ii); and

(B) in paragraph (3)(C)—

(i) by striking ''(C) FACILITY PAYMENT LIMIT.—'' and all that follows through ''Notwithstanding subsections'' and inserting the following:

''(C) FACILITY PAYMENT LIMIT.—Notwithstanding subsections''; and

(ii) by striking clause (ii).

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the day that is 1 year after the date of enactment of this Act.

SEC. 103. INSTITUTE OF MEDICINE MEDICARE PREVENTION BENEFIT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall contract with the Institute of Medicine of the National Academy of Sciences to—

(A) conduct a comprehensive study of current literature and best practices in the field of health promotion and disease prevention among medicare beneficiaries, including the issues described in paragraph (2); and

(B) submit the report described in subsection (b).

(2) ISSUES STUDIED.—The study required under paragraph (1) shall include an assessment of—

(A) whether each health promotion and disease prevention benefit covered under the medicare program is—

(i) medically effective (as defined in section 101(3)); or

(ii) a cost-effective benefit (as defined in section 101(1)) or a cost-saving benefit (as defined in section 101(2));

(B) utilization by medicare beneficiaries of such benefits (including any barriers to or incentives to increase utilization);

(C) quality of life issues associated with such benefits; and

(D) whether health promotion and disease prevention benefits that are not covered under the medicare program that would affect all medicare beneficiaries are—

(i) likely to be medically effective (as defined in section 101(3)); or

(ii) likely to be a cost-effective benefit (as defined in section 101(1)) or a cost-saving benefit (as defined in section 101(2));

(b) REPORTS.—

(1) THREE-YEAR REPORT.—On the date that is 3 years after the date of enactment of this Act, and each successive 3-year anniversary thereafter, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains—

(A) a detailed statement of the findings and conclusions of the study conducted under subsection (a); and

(B) the recommendations for legislation described in paragraph (3).

(2) INTERIM REPORT BASED ON NEW GUIDELINES.—If the United States Preventive Services Task Force or the Task Force on Community Preventive Services establishes new guidelines regarding preventive health benefits for medicare beneficiaries more than 1 year prior to the date that a report described in paragraph (1) is due to be submitted to the President, then not later than 6 months after the date such new guidelines are established, the Institute of Medicine of the National Academy of Sciences shall submit to the President a report that contains a detailed description of such new guidelines. Such report may also contain recommendations for legislation described in paragraph (3).

(3) RECOMMENDATIONS FOR LEGISLATION.—The Institute of Medicine of the National Academy of Sciences, in consultation with the United States Preventive Services Task Force and the Task Force on Community Preventive Services, shall develop recommendations in legislative form that—

(A) prioritize the preventive health benefits under the medicare program; and

(B) modify such benefits, including adding new benefits under such program, based on the study conducted under subsection (a).

(c) TRANSMISSION TO CONGRESS.—

(1) IN GENERAL.—Subject to paragraph (2), on the day that is 6 months after the date on which the report described in paragraph (1) of subsection (b) (or paragraph (2) of such subsection if the report contains recommendations in legislative form described in subsection (b)(3)) is submitted to the President, the President shall transmit the report and recommendations to Congress.

(2) REGULATORY ACTION BY THE SECRETARY OF HEALTH AND HUMAN SERVICES.—If the Secretary of Health and Human Services has exercised the authority under section 104(a) to adopt by regulation one or more of the recommendations under subsection (b)(3), the President shall only submit to Congress those recommendations under subsection (b)(3) that have not been adopted by the Secretary.

(3) DELIVERY.—Copies of the report and recommendations in legislative form required to be transmitted to Congress under paragraph (1) shall be delivered—

(A) to both Houses of Congress on the same day;

(B) to the Clerk of the House of Representatives if the House is not in session; and

(C) to the Secretary of the Senate if the Senate is not in session.

SEC. 104. AUTHORITY TO ADMINISTRATIVELY PROVIDE FOR COVERAGE OF ADDITIONAL PREVENTIVE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services may by regulation adopt any or all of the legislative recommendations developed by the Institute of Medicine of the National Academy of Sciences, in consultation with the United

States Preventive Services Task Force and the Task Force on Community Preventive Services in a report under section 103(b)(3) (relating to prioritizing and modifying preventive health benefits under the medicare program and the addition of new preventive benefits), consistent with subsection (b).

(b) ELIMINATION OF COST-SHARING.—With respect to items and services furnished under the medicare program that the Secretary has incorporated by regulation under subsection (a), the provisions of section 1833(p) of the Social Security Act (relating to elimination of cost-sharing for preventive benefits), as added by section 102(a), shall apply to those items and services in the same manner as such section applies to the items and services described in paragraphs (1) through (10) of such section.

(c) DEADLINE.—The Secretary must publish a notice of rulemaking with respect to the adoption by regulation under subsection (a) of any such recommendation within 6 months of the date on which a report described in section 103(b) is submitted to the President.

SEC. 105. FAST-TRACK CONSIDERATION OF PREVENTION BENEFIT LEGISLATION.

(a) RULES OF HOUSE OF REPRESENTATIVES AND SENATE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and is deemed a part of the rules of each House of Congress, but—

(A) is applicable only with respect to the procedure to be followed in that House of Congress in the case of an implementing bill (as defined in subsection (d)); and

(B) supersedes other rules only to the extent that such rules are inconsistent with this section; and

(2) with full recognition of the constitutional right of either House of Congress to change the rules (so far as relating to the procedure of that House of Congress) at any time, in the same manner and to the same extent as in the case of any other rule of that House of Congress.

(b) INTRODUCTION AND REFERRAL.—

(1) INTRODUCTION.—

(A) IN GENERAL.—Subject to paragraph (2), on the day on which the President transmits the report pursuant to section 103(c) to the House of Representatives and the Senate, the recommendations in legislative form transmitted by the President with respect to such report shall be introduced as a bill (by request) in the following manner:

(i) HOUSE OF REPRESENTATIVES.—In the House of Representatives, by the Majority Leader, for himself and the Minority Leader, or by Members of the House of Representatives designated by the Majority Leader and Minority Leader.

(ii) SENATE.—In the Senate, by the Majority Leader, for himself and the Minority Leader, or by Members of the Senate designated by the Majority Leader and Minority Leader.

(B) SPECIAL RULE.—If either House of Congress is not in session on the day on which such recommendations in legislative form are transmitted, the recommendations in legislative form shall be introduced as a bill in that House of Congress, as provided in subparagraph (A), on the first day thereafter on which that House of Congress is in session.

(2) REFERRAL.—Such bills shall be referred by the presiding officers of the respective Houses to the appropriate committee, or, in the case of a bill containing provisions within the jurisdiction of 2 or more committees, jointly to such committees for consideration of those provisions within their respective jurisdictions.

(c) CONSIDERATION.—After the recommendations in legislative form have been introduced as a bill and referred under subsection (b), such implementing bill shall be considered in the same manner as an implementing bill is considered under subsections (d), (e), (f), and (g) of section 151 of the Trade Act of 1974 (19 U.S.C. 2191).

(d) IMPLEMENTING BILL DEFINED.—In this section, the term ''implementing bill'' means only the recommendations in legislative form of the Institute of Medicine of the National Academy of Sciences described in section 103(b)(3), transmitted by the President to the House of Representatives and the Senate under subsection 103(c), and introduced and referred as provided in subsection (b) as a bill of either House of Congress.

(e) COUNTING OF DAYS.—For purposes of this section, any period of days referred to in section 151 of the Trade Act of 1974 shall be computed by excluding—

(1) the days on which either House of Congress is not in session because of an adjournment of more than 3 days to a day certain or an adjournment of Congress sine die; and

(2) any Saturday and Sunday, not excluded under paragraph (1), when either House is not in session.

Subtitle B—Expansion of Access to Health Promotion Services

SEC. 111. DISEASE SELF-MANAGEMENT DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary shall conduct demonstration projects for the purpose of promoting disease self-management for conditions identified, and appropriately prioritized, by the Secretary for target individuals (as defined in paragraph (2)).

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual who—

(A) is at risk for, or has, 1 or more of the conditions identified by the Secretary as being appropriate for disease self-management; and

(B) is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.), or enrolled under part B of such title (42 U.S.C. 1395j et seq.) or is enrolled under the Medicare+Choice program under part C of such title (42 U.S.C. 1395w–21 et seq.).

(b) NUMBER; PROJECT AREAS; DURATION.—

(1) NUMBER.—Not later than 2 years after the date of enactment of this Act, the Secretary shall implement a series of demonstration projects to carry out the purpose described in subsection (a)(1).

(2) PROJECT AREAS.—The Secretary shall implement the demonstration projects described in paragraph (1) in urban, suburban, and rural areas.

(3) DURATION.—The demonstration projects under this section shall be conducted during the 3-year period beginning on the date on which the initial demonstration project is implemented.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 18 months after the conclusion of the demonstration projects under this section, the Secretary shall submit a report to Congress on such projects.

(2) CONTENTS OF REPORT.—The report required under paragraph (1) shall include the following:

(A) A description of the demonstration projects.

(B) An evaluation of—

(i) whether each benefit provided under the demonstration projects is—

(I) medically effective;

(II) medically efficacious;

(III) cost-effective; or

(IV) cost-saving;

(ii) the level of the disease self-management attained by target individuals under the demonstration projects; and

(iii) the satisfaction of target individuals under the demonstration projects.

(C) Recommendations of the Secretary regarding whether to conduct the demonstration projects on a permanent basis.

(D) Such recommendations for legislation and administrative action as the Secretary determines to be appropriate.

(E) Any other information regarding the demonstration projects that the Secretary determines to be appropriate.

(d) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) an amount not to exceed $30,000,000 for the costs of carrying out this section.

SEC. 112. MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''MEDICARE HEALTH EDUCATION AND RISK APPRAISAL PROGRAM

''SEC. 1897. (a) ESTABLISHMENT.—Not later than 18 months after the date of the conclusion of the demonstration projects conducted under subsection (b)(1), the Secretary shall establish a comprehensive and systematic model for delivering health promotion and disease prevention services that—

''(1) through self-assessment identifies—

''(A) behavioral risk factors, such as tobacco use, physical inactivity, alcohol use, depression, lack of proper nutrition, and risk of falling, among target individuals;

''(B) needed medicare clinical preventive and screening health benefits among target individuals; and

''(C) functional and self-management information the Secretary determines to be appropriate;

''(2) provides ongoing followup to reduce risk factors and promote the appropriate use of preventive and screening health benefits;

''(3) improves clinical outcomes, satisfaction, quality of life, and appropriate use by target individuals of items and services covered under the medicare program; and

''(4) provides target individuals with information regarding the adoption of healthy behaviors.

''(b) DEMONSTRATION PROJECTS.—

''(1) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this section, the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, and the Director of the Agency for Healthcare Research and Quality, shall conduct demonstration projects for the purpose of developing a comprehensive and systematic model for delivering health promotion and disease prevention services described in subsection (a).

''(2) SELF-ASSESSMENT AND PROVISION OF INFORMATION.—The Secretary shall conduct the demonstration projects established under paragraph (1) in the following manner:

''(A) SELF-ASSESSMENT.—

''(i) IN GENERAL.—The Secretary shall test different—

''(I) methods of making self-assessments available to each target individual;

''(II) methods of encouraging each target individual to participate in the self-assessment; and

''(III) methods for processing responses to the self-assessment.

''(ii) CONTENTS.—A self-assessment made available under clause (i) shall include—

''(I) questions regarding behavioral risk factors;

''(II) questions regarding needed preventive screening health services;

''(III) questions regarding the target individual's preferences for receiving follow-up information; and

''(IV) other information that the Secretary determines appropriate.

''(B) PROVISION OF INFORMATION.—After each target individual completes the self-assessment, the Secretary shall ensure that the target individual is provided with such information as the Secretary determines appropriate, which may include—

''(i) information regarding the results of the self-assessment;

''(ii) recommendations regarding any appropriate behavior modification based on the self-assessment;

''(iii) information regarding how to access behavior modification assistance that promotes healthy behavior, including information on nurse hotlines, counseling services, provider services, and case-management services;

''(iv) information, feedback, support, and recommendations regarding any need for clinical preventive and screening health services or treatment; and

''(v) referrals to available community resources in order to assist the target individual in reducing health risks.

''(3) PROJECT AREAS AND DURATION.—

''(A) PROJECT AREAS.—The Secretary shall implement the demonstration projects in geographic areas that include urban, suburban, and rural areas.

''(B) DURATION.—The Secretary shall conduct the demonstration projects during the 3-year period beginning on the date on which the first demonstration project is implemented.

''(c) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on such projects.

''(2) CONTENTS OF REPORT.—The report submitted under paragraph (1) shall—

''(A) describe the demonstration projects conducted under this section;

''(B) identify the demonstration project that is the most effective; and

''(C) contain such other information regarding the demonstration projects as the Secretary determines appropriate.

''(3) MEASUREMENT OF EFFECTIVENESS.—For purposes of paragraph (2)(B), in identifying the demonstration project that is the most effective, the Secretary shall consider—

''(A) how successful the project was at—

''(i) reaching target individuals and engaging them in an assessment of the risk factors of such individuals;

''(ii) educating target individuals on healthy behaviors and getting such individuals to modify their behaviors in order to diminish the risk of chronic disease; and

''(iii) ensuring that target individuals were provided with necessary information;

''(B) the cost-effectiveness of the demonstration project; and

''(C) the degree of beneficiary satisfaction under the demonstration projects.

''(d) WAIVER AUTHORITY.—The Secretary may waive such requirements under this title as the Secretary determines necessary to carry out the demonstration projects under this section.

''(e) FUNDING.—There are authorized to be appropriated $25,000,000 to the Secretary for carrying out the demonstration projects under this section.

''(f) DEFINITION OF TARGET INDIVIDUAL.—The term 'target individual' means each individual who is—

''(1) entitled to benefits under part A or enrolled under part B, including an individual enrolled under the Medicare+Choice program under part C; or

''(2) between the ages of 50 and 64 and who is not described in paragraph (1).''.

Subtitle C—Medicare Coverage for Care Coordination and Assessment Services

SEC. 121. CARE COORDINATION AND ASSESSMENT SERVICES.

(a) SERVICES AUTHORIZED.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 112, is further amended by adding at the end the following new section:

''CARE COORDINATION AND ASSESSMENT SERVICES

''SEC. 1898. (a) PURPOSE.—The purpose of this section is to provide assistance to a beneficiary with a serious and disabling chronic condition (as defined in subsection (f)(1)) to obtain the appropriate level and mix of follow-up care.

''(b) ELECTION OF CARE COORDINATION AND ASSESSMENT SERVICES.—

''(1) IN GENERAL.—On or after January 1, 2003, a beneficiary with a serious and disabling chronic condition may elect to receive care coordination services in accordance with the provisions of this section under which, in appropriate circumstances, the eligible beneficiary has health care services covered under this title managed and coordinated by a care coordinator who is qualified under subsection (e) to furnish care coordination services under this section.

''(2) REVOCATION OF ELECTION.—An eligible beneficiary who has made an election under paragraph (1) may revoke that election at any time.

''(c) OUTREACH.—The Secretary shall provide for the wide dissemination of information to beneficiaries and providers of services, physicians, practitioners, and suppliers with respect to the availability of and requirements for care coordination services under this section.

''(d) CARE COORDINATION AND ASSESSMENT SERVICES DESCRIBED.—Care coordination services under this section shall include the following:

''(1) BASIC CARE COORDINATION AND ASSESSMENT SERVICES.—

''(A) IN GENERAL.—Except as otherwise provided in this section, eligible beneficiaries who have made an election under this section shall receive the following services:

''(i)(I) An initial assessment of an individual's medical condition, functional and cognitive capacity, and environmental and psychosocial needs.

''(II) Annual assessments after the initial assessment performed under subclause (I), unless the physician or care coordinator of the individual determines that additional assessments are required due to sentinel health events or changes in the health status of the individual that may require changes in plans of care developed for the individual.

''(ii) The development of an initial plan of care, and subsequent appropriate revisions to that plan of care.

''(iii) The management of, and referral for, medical and other health services, including multidisciplinary care conferences and coordination with other providers.

''(iv) The monitoring and management of medications.

''(v) Patient education and counseling services.

''(vi) Family caregiver education and counseling services.

''(vii) Self-management services, including health education and risk appraisal to identify behavioral risk factors through self-assessment.

''(viii) Providing access for consultations by telephone with physicians and other appropriate health care professionals, including 24-hour availability of such professionals for emergency consultations.

''(ix) Coordination with the principal nonprofessional caregiver in the home.

''(x) Managing and facilitating transitions among health care professionals and across settings of care, including the following:

''(I) Pursuing the treatment option elected by the individual.

''(II) Including any advance directive executed by the individual in the medical file of the individual.

''(xi) Activities that facilitate continuity of care and patient adherence to plans of care.

''(xii) Information about, and referral to, hospice services, including patient and family caregiver education and counseling about hospice, and facilitating transition to hospice when elected.

''(xiii) Such other medical and health care services for which payment would not otherwise be made under this title as the Secretary determines to be appropriate for effective care coordination, including the additional items and services as described in subparagraph (B).

''(B) ADDITIONAL BENEFITS.—The Secretary may specify additional benefits for which payment would not otherwise be made under this title that may be available to eligible beneficiaries who have made an election under this section (subject to an assessment by the care coordinator of an individual beneficiary's circumstances and need for such benefits) in order to encourage the receipt of, or to improve the effectiveness of, care coordination services.

''(2) CARE COORDINATION AND ASSESSMENT REQUIREMENT.—Notwithstanding any other provision of this title, with respect to items and services for which payment is made under this title furnished to a beneficiary for the diagnosis and treatment of the beneficiary's serious and disabling chronic condition, if the beneficiary has made an election to receive care coordination and assessment services under this section, the Secretary may require that payment may only be made under this title for such items and services relating to such condition if the items and services have been furnished by or coordinated through the care coordinator. Under such provision, the Secretary shall prescribe exceptions for emergency medical services (as described in section 1852(d)(3), but without regard to enrollment with a Medicare+Choice organization), and other exceptions determined by the Secretary for the delivery of timely and needed care.

''(e) CARE COORDINATORS.—

''(1) CONDITIONS OF PARTICIPATION.—In order to be qualified to furnish care coordination and assessment services under this section, an individual or entity shall—

''(A) be a health care professional or entity (which may include physicians, physician group practices, or other health care professionals or entities the Secretary may find appropriate) meeting such conditions as the Secretary may specify;

''(B) enter into a care coordination agreement under paragraph (2); and

''(C) meet such criteria as the Secretary may establish (which may include experience in the provision of care coordination or primary care physician's services).

''(2) AGREEMENT TERM; PAYMENT.—

''(A) DURATION AND RENEWAL.—A care coordination agreement under this subsection shall—

''(i) be entered into for a period of 1 year and may be renewed if the Secretary is satisfied that the care coordinator continues to meet the conditions of participation specified in paragraph (1);

''(ii) assure the compliance of the care coordinator with such data collection and reporting requirements as the Secretary determines necessary to assess the effect of care coordination on health outcomes; and

''(iii) contain such other terms and conditions as the Secretary may require.

''(B) PAYMENT FOR SERVICES.—The Secretary shall establish payment terms and conditions and payment rates for basic care coordination and assessment services described in subsection (d)(1). The Secretary may establish new billing codes to carry out the provisions of this subparagraph.

''(f) DEFINITIONS.—In this section:

''(1) SERIOUS AND DISABLING CHRONIC CONDITION.—The term 'serious and disabling chronic condition' means, with respect to an individual, that the individual has at least one physical or mental condition and a licensed health care practitioner has certified within the preceding 12-month period that—

''(A) the individual has a level of disability such that the individual is unable to perform (without substantial assistance from another individual) for a period of at least 90 days due to a loss of functional capacity—

''(i) at least 2 activities of daily living; or

''(ii) such number of instrumental activities of daily living that is equivalent (as determined by the Secretary) to the level of disability described in clause (i);

''(B) the individual has a level of disability equivalent (as determined by the Secretary) to the level of disability described in subparagraph (A); or

''(C) the individual requires substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

''(2) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' means each of the following:

''(A) Eating.

''(B) Toileting.

''(C) Transferring.

''(D) Bathing.

''(E) Dressing.

''(F) Continence.

''(3) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term 'instrumental activities of daily living' means each of the following:

''(A) Medication management.

''(B) Meal preparation.

''(C) Shopping.

''(D) Housekeeping.

''(E) Laundry.

''(F) Money management.

''(G) Telephone use.

''(H) Transportation use.

''(4) BENEFICIARY.—The term 'beneficiary' means an individual entitled to benefits under part A, or enrolled under part B, including an individual enrolled under the Medicare+Choice program under part C.''.

(b) COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES AS A PART B MEDICAL SERVICE.—

(1) IN GENERAL.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended—

(A) in the second sentence, by redesignating paragraphs (16) and (17) as clauses (i) and (ii); and

(B) in the first sentence—

(i) by striking ''and'' at the end of paragraph (14);

(ii) by striking the period at the end of paragraph (15) and inserting ''; and''; and

(iii) by adding after paragraph (15) the following new paragraph:

''(16) care coordination and assessment services furnished by a care coordinator in accordance with section 1866C.''.

(2) CONFORMING AMENDMENTS.—Sections 1864(a) 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of such Act (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are each amended by striking ''paragraphs (16) and (17)'' each place it appears and inserting ''clauses (i) and (ii) of the second sentence''.

(3) PART B COINSURANCE AND DEDUCTIBLE NOT APPLICABLE TO CARE COORDINATION AND ASSESSMENT SERVICES.—

(A) COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by sections 105 and 223 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554, is amended—

(i) by striking ''and'' at the end of subparagraph (T); and

(ii) by inserting before the final semicolon '', and (V) with respect to care coordination and assessment services described in section 1861(s)(16) that are furnished by, or coordinated through, a care coordinator, the amounts paid shall be 100 percent of the payment amount established under section 1866C''.

(B) DEDUCTIBLE.—Section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended—

(i) by striking ''and'' at the end of paragraph (5); and

(ii) by inserting before the final period '', and (7) such deductible shall not apply with respect to care coordination and assessment services (as described in section 1861(s)(16))''.

(C) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—The third sentence of section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)), as amended by section 102(b)(2), is further amended by inserting after ''section 1833(p),'' the following: ''with respect to care coordination and assessment services (as described in section 1861(s)(16)),''.

TITLE II—PAYMENT INCENTIVES FOR QUALITY CARE FOR INDIVIDUALS WITH SERIOUS AND DISABLING CHRONIC CONDITIONS

SEC. 201. ADJUSTMENTS TO FEE-FOR-SERVICE PAYMENT SYSTEMS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for appropriate adjustments to each of the payment systems described in subsection (b) to take into account the additional costs incurred in providing items and services under the medicare program to medicare beneficiaries who suffer from serious and disabling chronic conditions, including the consideration of the patient classification system (or other methodology) under subsection (d). The Secretary shall implement such adjustments for items and services furnished on or after October 1, 2005.

(b) PAYMENT SYSTEMS DESCRIBED.—The payment systems referred to in subsection (a) are the following:

(1) The prospective payment system for covered skilled nursing facility services under section 1888(e) of such Act (42 U.S.C. 1395yy(e)).

(2) The prospective payment system for home health services under section 1895 of such Act (42 U.S.C. 1395fff).

(3) The prospective payment system for outpatient hospital services under section 1833(t) of such Act (42 U.S.C. 1395l(t)).

(4) The physician fee schedule under section 1848 of such Act (42 U.S.C. 1395w–4).

(5) The composite rate of payment for dialysis services under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)).

(6) The payment rate for outpatient therapy services and comprehensive outpatient rehabilitation services under section 1834(k) of such Act (42 U.S.C. 1395m(k)).

(7) The payment rate for partial hospitalization services established by the Secretary in regulations under title XVIII of such Act.

(8) The payment rate for hospice services under section 1814(i) of such Act (42 U.S.C. 1395f(i)).

(c) INTERIM REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the proposed adjustments required under subsection (a) to the payment systems described in subsection (b), the methodology employed by the Secretary in providing for such proposed adjustments, and an assessment of the impact of such adjustments on access to effective care for medicare beneficiaries.

(d) PATIENT CLASSIFICATION SYSTEM.—The Secretary shall develop a patient classification system or other methodology to predict costs within and across postacute care settings attributable to furnishing items and services to medicare beneficiaries who suffer from serious and disabling chronic conditions. The Secretary shall develop such system by not later than October 1, 2004, and shall consult with representatives of providers of services and individuals with expertise in health care financing and risk adjustment methodology in developing such system.

SEC. 202. MEDICARE+CHOICE.

(a) REVISIONS TO RISK ADJUSTMENT METHODOLOGY.—

(1) IN GENERAL.—The Secretary shall revise the risk adjustment methodology under section 1853(a)(3) of the Social Security Act (42 U.S.C. 1395w–23(a)(3)) applicable to payments to Medicare+Choice organizations offering specialized programs for frail elderly and at-risk beneficiaries to take into account variations in costs incurred by such organizations.

(2) METHODS CONSIDERED.—In revising the risk adjustment methodology under paragraph (1), the Secretary shall consider—

(A) hybrid risk adjustment payment systems, such as partial capitation;

(B) new diagnostic and service markers that more accurately predict high risk;

(C) improving the structural components of the applicable method of payment, such as reducing payment lag, using multiple site diagnostic data, and using several years of data;

(D) providing for adjustments to payment amounts for beneficiaries with comorbidities;

(E) testing concurrent risk adjustment methodologies; and

(F) testing payment methods using data from specialized programs for frail elderly and at-risk beneficiaries.

(3) IMPLEMENTATION.—The Secretary shall implement such revisions to the risk adjustment methodology for items and services furnished on or after January 1, 2005.

(4) INTERIM REPORT.—Not later than January 1, 2004, the Secretary shall submit to Congress a report on revision of the risk adjustment methodology required under paragraph (1), including a description of the methods considered and employed by the Secretary in providing for such revision and an assessment of the impacts of such methods on access to effective care for medicare beneficiaries.

(b) INTERIM CONTINUATION OF BLENDED RATE FOR SPECIALIZED PROGRAMS FOR FRAIL ELDERLY AND AT-RISK MEDICARE BENEFICIARIES RESIDING IN INSTITUTIONS.—

(1) IN GENERAL.—In the case of a Medicare+Choice organization that complies with the requirements under paragraph (2) and that offers a Medicare+Choice plan that provides for a specialized program for frail elderly and at-risk beneficiaries that exclusively serves beneficiaries in institutions or beneficiaries that are entitled to medical assistance under a State plan under title XIX, notwithstanding section 1853(a)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(a)(3)(C)(ii)), such organization shall be paid according to the method described in section 1853(a)(3)(C)(ii)(I) until such time as

the Secretary has implemented the revised risk adjustment methodology required in subsection (a).

(2) REQUIREMENTS.—A Medicare+Choice organization may not qualify for the payment methodology under paragraph (1) unless the organization collects such data (and in such format) as the Secretary requires to monitor quality of services provided, outcomes, and costs, including functional and diagnostic data and information collected through the Health Outcomes Survey.

(c) INTERIM CONTINUATION OF PAYMENT METHODOLOGIES FOR DEMONSTRATION PROGRAMS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, payment methodologies for medicare demonstration programs for specialized programs for frail elderly and at-risk beneficiaries that comply with the requirements under paragraph (2) shall continue under the terms and conditions of the demonstration authority, including the risk adjustment factors and formula used for paying such demonstration programs, until such time as the Secretary has implemented the revised risk adjustment methodology required in subsection (a).

(2) REQUIREMENTS.—A medicare demonstration program may not qualify for the payment methodology under paragraph (1) unless the program collects such data (and in such format) as the Secretary requires to monitor quality of services provided, outcomes, and costs, including functional and diagnostic data and information collected through the Health Outcomes Survey.

(d) INTERIM DEMONSTRATION PROGRAM FOR ADDITIONAL PAYMENTS FOR SPECIALIZED PROGRAMS.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program under which additional payments (in such manner and amount as the Secretary determines appropriate) may be made to a Medicare+Choice organization that complies with the requirements under paragraph (2) and that offers a Medicare+Choice plan that—

(A) provides, directly or through contract, for a specialized program of care for enrollees with serious and disabling chronic conditions; and

(B) exclusively serves enrollees with serious and disabling chronic conditions or serves a disproportionate share of such enrollees.

(2) REQUIREMENTS.—A Medicare+Choice organization may not qualify for additional payments under paragraph (1) unless the organization and the specialized program of care meet the following requirements:

(A) Under the specialized program of care, a clinical delivery system is established that meets the needs of such enrollees, including—

(i) methods to prevent, delay, or minimize the progression of disabilities;

(ii) disease management protocols, such as high risk screening to identify risk of hospitalization, nursing home placement, functional decline, death, and other factors that increase the costs of care provided;

(iii) appropriate specially trained health care staff, such as nurse practitioners, geriatric care managers, or mental health professionals; and

(iv) methods for promoting integration of care, financing, and administrative functions across health care settings.

(B) The organization collects such data (and in such format) as the Secretary requires to monitor quality of services provided, outcomes, and costs, including functional and diagnostic data and information collected through the Health Outcomes Survey.

(C) The organization employs quality standards and tracks quality indicators specified by the Secretary that are relevant to the special needs of enrollees with serious and disabling chronic conditions.

(D) The organization does not receive payments, or adjustment to payments, with respect to any enrollee by reason of subsection (b) or (c).

(3) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary to carry out this demonstration program.

(4) TERMINATION.—The demonstration program under this subsection shall terminate 1 year after such time as the Secretary has implemented the revised risk adjustment methodology required in subsection (a).

(5) FUNDING.—There are authorized to be appropriated to the Secretary $25,000,000 for carrying out the demonstration program under this subsection.

(e) DEFINITION.—In this section, the term ''specialized programs for frail elderly and at-risk beneficiaries'' means—

(1) demonstrations approved by the Secretary for purposes of testing the integration of acute and expanded care services under prepaid financing which include prescription drugs and other noncovered ancillary services, care coordination, and home and community-based services, such as the social health maintenance organization demonstration project authorized under section 2355 of the Deficit Reduction Act of 1984 and expanded under section 4207(b)(4)(B)(i) of the Omnibus Reconciliation Act of 1990;

(2) demonstrations approved by the Secretary for purposes of improving quality of care and preventing hospitalizations for nursing home residents, such as the EverCare demonstration project;

(3) demonstrations approved by the Secretary for purposes of testing methods for integrating medicare and medicaid benefits for the dually eligible, such as the Minnesota Senior Health Options program, the Wisconsin Partnership program, the Massachusetts Senior Care Organization program, and the Rochester Community Care Network program;

(4) demonstrations approved by the Secretary under subsection (d); and

(5) such other demonstrations or programs approved by the Secretary for similar purposes, as determined by the Secretary.

TITLE III—DEVELOPMENT OF NATIONAL POLICIES ON EFFECTIVE CHRONIC CONDITION CARE

SEC. 301. STUDY AND REPORT ON EFFECTIVE CHRONIC CONDITION CARE.

(a) STUDY.—For purposes of improving chronic condition care furnished to medicare beneficiaries under the medicare program, the Secretary of Health and Human Services shall conduct a comprehensive study of chronic condition trends of medicare beneficiaries and associated service utilization, quality indicators, and cumulative costs.

(b) SPECIFIC MATTERS STUDIED.—The study conducted under subsection (a) shall include an assessment of the following:

(1) Chronic condition prevalence rates.

(2) Demographic, medical, and functional information about medicare beneficiaries with chronic conditions.

(3) Utilization, cost, and quality data across settings, including—

(A) expenditures under a State plan under title XIX of the Social Security Act for individuals dually eligible for benefits under the medicare and medicaid programs,

(B) data on out-of-pocket expenses paid by medicare beneficiaries,

(C) data on payments made by non-Federal health insurance programs,

(D) amounts and percentages of overall payments made to medicare providers of services and suppliers for medicare beneficiaries with chronic conditions, and

(E) current and future cost-shifting for treatment of such beneficiaries between the medicare and medicaid programs.

(c) INFORMATION.—

(1) IN GENERAL.—The Secretary may collect such data from providers of services, suppliers, fiscal intermediaries, and carriers. Such providers, suppliers, fiscal intermediaries, and carriers shall furnish to the Secretary the data the Secretary requires to conduct the study under subsection (a).

(2) REQUIREMENT TO CONSIDER DATA PREVIOUSLY COLLECTED.—To the maximum extent practicable, in conducting the study, the Secretary shall analyze existing data and utilize existing data collection methodologies.

(3) CONSULTATION.—The Secretary shall consult with representatives of providers of services, suppliers, fiscal intermediaries, and carriers with respect to data collection requirements to conduct the study with respect to the specific matters described in subsection (b).

(d) REPORT.—

(1) IN GENERAL.—Not later than 3 years after the date of enactment of this Act, and triennially thereafter, the Secretary shall submit to Congress a report on the study conducted under subsection (a) and the specific matters studied under subsection (b).

(2) RECOMMENDATIONS.—Each report shall also include specific recommendations with respect to appropriate care for medicare beneficiaries with chronic conditions, including the establishment, and refinement, of goals for reducing chronic condition prevalence rates and related medical expenses.

(e) DEFINITION.—In this section, the term ''chronic condition'' means one or more physical or mental conditions which are likely to last for an unspecified period of time, or for the duration of an individual's life, for which there is no known cure, and which may affect an individual's ability to carry out basic activities of daily living, instrumental activities of daily living, or both.

(f) REDUCTION OF PAPERWORK; ASSISTANCE WITH DEVELOPMENT OF COMPUTER-ASSISTED PAPERWORK REDUCTION TECHNOLOGY.—

(1) REDUCTION OF PAPERWORK.—Not later than one year after the date of enactment of this Act, the Secretary shall, in consultation with providers of services and suppliers under the medicare program, patient advocacy groups, and State and local health care administration experts, implement a program to eliminate or simplify those paperwork requirements that are not required by law, and do not contribute to the quality of care furnished to medicare beneficiaries or the integrity of the medicare program.

(2) DEVELOPMENT OF BEST PRACTICES SOFTWARE.—

(A) IN GENERAL.—The Secretary, through the Office of Research and Development of the Center for Medicare and Medicaid Services, shall develop and disseminate to providers of services and suppliers participating in the medicare program best practices electronic software and medical technology information systems designed to reduce the duplicative recording of information, to reduce the need for handwritten entries, and to reduce the risk of medical and pharmaceutical errors in data entry.

(B) TECHNICAL ASSISTANCE.—The Secretary shall provide for technical assistance in the use of the electronic software developed under subparagraph (A).

(C) AUTHORIZATION OF APPROPRIATIONS.—For each of fiscal years 2002, 2003, and 2004, there are authorized to be appropriated to the Secretary $10,000,000 to carry out this paragraph.

SEC. 302. INSTITUTE OF MEDICINE MEDICARE CHRONIC CONDITION CARE IMPROVEMENT STUDY AND REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall contract with the Institute of Medicine of the National Academy of Sciences to—

(A) conduct a comprehensive study of the medicare program to identify—

(i) factors that facilitate access to effective care (including, where appropriate, hospice care) for medicare beneficiaries with chronic conditions; and

(ii) factors that impede access to such care for such beneficiaries,

including the issues studied under paragraph (2); and

(B) submit the report described in subsection (b).

(2) ISSUES STUDIED.—The study required under paragraph (1) shall—

(A) identify inconsistent clinical, financial, or administrative requirements across provider and supplier settings or professional services with respect to medicare beneficiaries;

(B) identify requirements under the program imposed by law or regulation that—

(i) promote costshifting across providers and suppliers;

(ii) impede access to effective chronic condition care by requiring the demonstration of continuing clinical improvement of the condition as a prerequisite to coverage of certain benefits;

(iii) impose unnecessary burdens on such beneficiaries and their family caregivers;

(iv) impede coverage for services that prevent, delay, or minimize the progression of chronic conditions;

(v) impede the establishment of administrative information systems to track health status, utilization, cost, and quality data across providers and suppliers and provider settings;

(vi) impede the establishment of clinical information systems that support continuity of care across settings and over time;

(vii) impede the alignment of financial incentives among the medicare program, the medicaid program, and group health plans and providers and suppliers that furnish services to the same beneficiary; or

(viii) impede payment methods that encourage the enrollment of high-risk populations, support innovation, or encourage providers and suppliers to maintain or improve health status for such medicare beneficiaries.

(b) REPORT.—On the date that is 18 months after the date of enactment of this Act, the Institute of Medicine of the National Academy of Sciences shall submit to Congress and the Secretary of Health and Human Services a report that contains—

(1) a detailed statement of the findings and conclusions of the study conducted under subsection (a); and

(2) recommendations to improve access to effective care for medicare beneficiaries with chronic conditions.

SUMMARY OF THE MEDICARE CHRONIC CARE IMPROVEMENT ACT OF 2001

TITLE I—EXPANSION OF BENEFITS TO PREVENT, DELAY, AND MINIMIZE THE PROGRESSION OF CHRONIC CONDITIONS

Improve access to preventive services

Eliminate deductibles and co-insurance for Medicare covered preventive services.

Streamline process of approving preventive benefits by directing the Secretary of Health and Human Services to contract with the Institute of Medicine (IOM) to investigate and recommend new preventive benefits every 3 years. Grant the Secretary the authority to implement these recommendations, and fast-track the recommendations through Congress if the Secretary chooses not to act upon this authority.

Expand access to health promotion services

Establish demonstration projects to promote disease self-management.

Implement a Medicare health education and risk appraisal program no later than 18 months after a series of demonstration projects conclude.

Expand coverage for care coordination and assessment services

Create a new benefit that covers assessment, care coordination, counseling, and education assistance for individuals with serious and disabling chronic conditions. Services could be provided by health care professionals, including physicians, social workers, and nurses.

Examples of items and services to be covered include: initial and periodic health screening and assessments; management and referral for medical and other health services; medication management; and patient and family caregiver education and counseling.

TITLE II—ESTABLISH PAYMENT INCENTIVES FOR FURNISHING QUALITY SERVICES TO INDIVIDUALS WITH SERIOUS AND DISABLING CHRONIC CONDITIONS

Improve medicare financing methods

Direct the Secretary to refine Medicare prospective payment systems for skilled nursing facility (SNF), home health, therapy, partial hospitalization, end stage renal dialysis (ESRD), and outpatient hospital services and refine resource-based relative value scale (RBRVS) payment methods for physicians to ensure appropriate payment for serving individuals with serious and disabling chronic conditions.

Direct the Secretary to refine Medicare+Choice risk adjustment methodology to provide adequate payment for plans with specialized programs for frail elderly and at-risk beneficiaries.

Until the refined risk adjustment methodology is implemented, direct the Secretary to continue current payment methodologies for existing specialized programs for frail elderly and at-risk beneficiaries.

Create a demonstration program to provide additional payments to Medicare+Choice plans that provide a specialized program of care for beneficiaries with serious and disabling chronic conditions. These plans must exclusively serve such beneficiaries or serve a disproportionate share of such beneficiaries. The demonstration program would expire one year after the refund risk adjustment methodology is implemented.

TITLE III—STUDY AND REPORT ON EFFECTIVE CHRONIC CONDITION CARE

Evaluate Medicare policies regarding chronic condition care

Direct the Secretary to study chronic condition trends and associated service utilization, cumulative costs, and quality indicators in Medicare.

Direct the Secretary to report the study results to Congress every 3 years. The report must include recommendations on improving care for Medicare beneficiaries with chronic conditions, reducing chronic conditions, and reducing related medical expenses.

Identify improvements in Medicare to ensure effective chronic condition care

Direct the Secretary to contract with the IOM to investigate and identify barriers and facilitators to effective care for Medicare beneficiaries with chronic conditions, including inconsistent clinical, financial, or administrative requirements across care settings. The IOM's report must include recommendations to improve access to effective care.

Definitions

''Chronic condition'' means one or more physical or mental conditions which are likely to last for an unspecified period of time, or for the duration of an individual's life, for which there is no known cure, and which may affect an individual's ability to carry out basic activities of daily living (ADLs), instrumental activities of daily living (IADLs), or both.

''Serious and disabling chronic condition(s)'' means the individual has one or more physical or mental conditions and has been certified by a licensed health care practitioner within the preceding 12 months as having a level of disability such that the individual, for at least 90 days, is unable to perform at least 2 ADLs or a number of IADLs or other measure indicating an equivalent level of disability or requiring substantial supervision due to severe cognitive impairment.

By Mr. NELSON of Florida:

S. 1592. A bill to amend title XI of the Social Security Act to prohibit Federal funds from being used to provide payments under a Federal health care program to any health care provider who charges a membership or any other extraneous or incidental fee to a patient as a prerequisite for the provision of an item or services to the patient; to the Committee on Finance.

Mr. NELSON of Florida. Mr. President, I am pleased to introduce the Medicare Equal Access to Care Act. I am jointed by my colleagues Senators DURBIN and EDWARDS. This legislation is designed to address a disturbing development which may make it harder for some seniors to have access to Medicare.

I have recently become aware of a practice, an early example if which took place in Florida, in which doctors assess their existing patients a $1,500 membership fee in order to receive continued care. In some States, these fees have been as high as $20,000. By charging these extraneous and unwarranted dues, the doctors can shrink their practice, yet maintain their profits. Another version of this arrangement is to require that patients seek and pay for non-Medicare covered services from their doctors as a condition for joining or remaining in the practice. Tragically, the patients who can't afford these large sums for the privilege of medical care or who choose not to purchase non-Medicare covered services are simply told to find another doctor. In areas where there is already a shortage of doctors, this practice could severely hamper Medicare beneficiaries' access to health care.

Then, in addition to membership fees the doctors bill Medicare for the cost of the covered services they provide.

Were Medicare a private insurance company, this practice would not be allowed. Private health insurance companies do not permit their providers to charge an ''access fee'' as a condition to being accepted as a patient. The Federal Government, the American taxpayers, should not hold its providers to a looser standard, thereby supporting a distasteful division of Medicare beneficiaries into haves and have-nots. This situation is unacceptable.

The Medicare Equal Access to Care Act bill will put a damper on such agreements. This legislation is simple: it will prevent any federal health program, like Medicare, from reimbursing doctors who charge their patients membership fees, as defined by the Secretary of Health and Human Services, or who require that their patients purchase non-Medicare.

I want to emphasize that this legislation does not interfere with the right of the doctor and patient to enter into private arrangements. A doctor may forego Medicare reimbursement and charge patients a membership fee of any amount, and patients have the choice of whether to accept that condition. Likewise, a doctor is free to charge a patient for any service that is not reimbursed under Medicare.

Though they present a carefully crafted loophole, these arrangements violate the intent and spirit of the Balanced Billing Act.

Clearly, our health care system is not working for patients. Additionally it's not working for doctors, if they must resort to these types of practices. Also, hundreds of thousands of our nation's seniors have been informed that their managed care company will be withdrawing from the Membership program. We need to adequately reimburse doctors, to provide the incentive to continue to participate in the Medicare+Choice program. Just as we don't want Medicare beneficiaries to be told their HMO is unavailable, we don't want them to be told their doctor is unavailable, unless they pay a fee. These are among these reasons that Congress needs to complete and pass a Patient's Bill of Rights and send it to the President. But in the meantime, we must protect our seniors and ensure that their access to Medicare is not subject to hurdles and conditions.

I look forward to working with my colleagues to pass the Medicare Equal Access to Care Act.

I ask unanimous consent that the text of the Bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1592

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Equal Access to Care Act''.

SEC. 2. LIMITATION ON PAYMENTS TO PROVIDERS UNDER A FEDERAL HEALTH CARE PROGRAM.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

''SEC. 1128G. LIMITATION ON PAYMENTS TO PROVIDERS UNDER A FEDERAL HEALTH CARE PROGRAM.

''(a) IN GENERAL.—No Federal funds shall be used to provide payments under a Federal health care program to any physician (as defined in section 1861(r)), practitioner (as described in section 1842(b)(18)(C)), or other individual who charges a membership fee or any other extraneous or incidental fee to a patient, or requires a patient to purchase an item or service, as a prerequisite for the provision of an item or service to the patient.

''(b) FEDERAL HEALTH CARE PROGRAM DEFINED.—In this section, the term 'Federal health care program' has the meaning given that term under section 1128B(f) except that, for purposes of this section, such term includes the health insurance program under chapter 89 of title 5, United States Code.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to payments made on or after the date of enactment of this Act.

By Mr. JEFFORDS (for himself, Mr. SMITH of New Hampshire, and Mr. CRAPO):

S. 1593. A bill to authorize the Administrator of the Environmental Protection Agency to establish a grant program to support research projects on critical infrastructure protection for water supply systems, and for other purposes; to the Committee on Environment and Public Works.

Mr. JEFFORDS. Mr. President, Members of the Senate, I rise before you today to introduce the Water Infrastructure Security and Research Development Act. This legislation authorizes the U.S. Environmental Protection Agency to provide funding to support research projects on critical infrastructure protection for water supply systems.

Our Nation's water supply system is truly unique. It uses a decentralized, community-based approach to provide superior water services to all citizens of the United States. Here, we turn on the tap in our homes and receive clean, fresh water without giving it much thought. This not the way water systems operate throughout the world.

A 1997 United Nations report on the state of water resources worldwide states that at least one-fifth of all people do not have access to safe drinking water, and more than one-half lack adequate sanitation. Quoting from the report:

> The World Health Organization estimates that a total of more than five million people die each year just from diseases caused by unsafe drinking water, and a lack of sanitation and water for hygiene. Provision of safe drinking water and sanitation could reduce the amount of illness and death by as much as three-quarters, depending on the disease.

In this country, we often take our water system for granted. When considered in the international context, the true value of our water system becomes more apparent. We truly have something to protect.

During my tenure as Chairman of the Environment and Public Works Committee, we have been evaluating the state of our Nation's water infrastructure, both drinking water and wastewater. It is clear that we have work to do to modernize our existing systems and ensure that we continue to provide clean, safe water to our citizens into the future. Our discussions in the Committee tend to focus on infrastructure replacement needs, the funds that will be required, and the extent of the federal role. I am committed to this process, and I look forward to continuing to work with my colleagues on legislation that we plan to introduce early next year.

However, today, I rise to speak to you about another aspect of our Nation's water infrastructure—security. Since the events of September 11, I have worked with the members of the Environment and Public Works Committee and the Environmental Protection Agency to ensure that we are taking the steps necessary to protect our nation's water infrastructure system during these times. There are many short term actions that have already been taken.

Based on the recommendations of Presidential Decision Directive 63, issued by President Clinton in 1998, the Environmental Protection Agency and its industry partner, the Association of Metropolitan Water Agencies, have established a communications system, a water infrastructure Information Sharing and Analysis Center, designed to provide real-time threat assessment data to water utilities throughout the nation.

Through this partnership, the Environmental Protection Agency and the Association of Metropolitan Water Agencies are working to develop generic assessment tools that individual water utilities can use to assess their facilities for potential physical and cyber threats. I believe that the rapid completion of both these tools and the individual assessments is imperative. In early October, I sent a letter to the President with Senators SMITH, GRAHAM, and CRAPO and Representatives TAUZIN, DINGELL, GILLMOR, and PALLONE requesting that he use a portion of the $20 billion of discretionary funds provided to the Administration by Congress this year to provide assistance for these assessments to water utilities.

The legislation I am introducing today with Senator SMITH will take us one step further by authorizing support of both ongoing efforts under Presidential Decision Directive 63 and new research to assess potential threats to our water supply system and develop solutions.

This legislation authorizes twelve million dollars per year from 2002 to 2007 for the Environmental Protection Agency to use for grants to or cooperative agreements with research institutions. Projects conducted under these agreements will be used to conduct research addressing physical and cyber threats at water supply systems, improvements in information sharing and analysis efforts, and technical assistance and training. These projects will address both drinking water and wastewater systems that make up our nation's water supply infrastructure.

Eligible research institutions will include public and private entities, including national laboratories that perform research that will improve the security of water supply systems. Our legislation includes a provision to ensure that those entities conducting this research have the ability to effectively safeguard sensitive information.

Individual projects will fall into a series of categories designed to develop the information we need to protect our water supply system nationwide.

First, projects will assess the security issues for water supply systems by conducting assessments and developing and refining vulnerability assessment tools.

Second, projects will protect water supply systems from potential threats by developing technologies, processes, guidelines, standards, and procedures for the purpose of protecting water supply systems. Projects will also develop real-time monitoring systems to protect against chemical, biological, or radiological attack.

Third, projects will develop technologies and processes for addressing the mitigation, response and recovery of biological, chemical and radiological contamination of water supply systems.

Fourth, projects will implement requirements of Presidential Decision Directive 63 by refining and operating the Information Sharing and Analysis Center to capture and share threats, events and best practices.

Finally, projects will test and evaluate new technologies and processes by developing regional ''pilot facilities'' to demonstrate upgraded security systems, assess new technologies, and to determine operational and cost impacts due to enhanced security.

Individual awards may not exceed one million dollars. Test and evaluation projects will be cost-shared on a 50–50 basis.

I look forward to working with my colleagues on this legislation and other efforts to enhance the security of our Nation's water infrastructure in the weeks, months, and years to come. We truly have something to protect; clean, safe, fresh water is worth our investment.

By Mrs. CLINTON (for herself, Mr. SMITH of Oregon, Mr. KENNEDY, and Mrs. MURRAY):

S. 1594. A bill to amend the Public Health Service Act to provide programs to improve nurse retention, the nursing workplace, and the quality of care; to the Committee on Health, Education, Labor, and Pensions.

Mrs. CLINTON. Mr. President, I am proud to introduce today the Nurse Retention and Quality Care Act of 2001 and to speak about the importance of nurses and the work they do. On September 11, nurses were among those who were on the front lines of the battle against terrorism. With courage, skill and determination, they were on the job, treating the injured, helping to save lives.

To this day, nurses are defending America. In clinics, hospitals and offices around the country, they are working to detect and treat actual or suspected cases of anthrax. Should our Nation face other biological threats or terrorist attacks, nurses will be there for us.

Today's news that a woman who works in the Manhattan Eye, Ear and Throat Hospital is in critical condition with possible inhalation anthrax is a reminder of the hazards faced by health care workers. And it is a reminder of how important it is that our public health system be fully staffed with trained health care professionals.

Sadly, America is facing a nursing shortage at a time when the need for more nurses is so clear. Our nurses are facing an emergency of their own and they need our help. The nursing shortage imposes increasing hardship on hospitals and nurses alike, and threatens the ability of our health care system to provide basic patient care, much less respond to health crises and terrorism.

Not only is the number of individuals entering the nursing profession falling, but hospitals are also facing difficulty retaining the nurses already on staff. Fifty percent of nurses say they have recently considered leaving their jobs for reasons other than retirement, and approximately half a million licensed nurses are not currently practicing nursing. Many of the nurses who have considered leaving the profession cite their low level of overall job satisfaction.

While we must do more to improve the number of nurses in training, we must also take steps to enhance the workplace to retain current nurses, and that is what the bill that Senator GORDON SMITH and I will be introducing today would address.

One way to retain nurses is to follow the example of those hospitals that have become nursing ''magnets.'' They are successful because they involve nurses in decision-making, encourage collaboration among health professionals, give nurses the opportunity to pursue continuing education and advancement, and they organize care to improve patient outcome.

Our bill is designed to encourage more hospitals to follow these leads. And I am pleased that hospitals and nurses support this bill. It has been endorsed by the American Nurses Association and the American Hospitals Association.

It is also a good bill for patients and their quality of care as well. Research has shown that magnet hospitals have lower mortality rates, shorter lengths of stay, higher patient satisfaction and cost-efficiency.

As our Nation faces increasing threats of terrorist and biological attack, our health system must be stronger than ever before. One of the best ways we can do this is by taking steps to reverse the nursing shortage, and ensure that nurses on the front lines are well-prepared to respond to emergencies.

Our bill does both. First, it creates demonstration programs to encourage states to adopt magnet hospital practices, which will help attract and retain the nursing staff our hospitals need so they can cope with surges in patient volume.

And, second, our bill encourages nurses to pursue continued education. That is so important today, when we need more health care professionals who can detect the early signs of a bioterrorist attack. This legislation will promote the kind of training that the New York State Nurses Association, Bellevue Hospital and New York College provide for nurses in my state.

Mr. SMITH of Oregon. Mr. President, I rise today to join my colleague from New York, Senator CLINTON, in introducing the Nurse Retention and Quality of Care Act of 2001. As most of my colleagues already know, our Nation is facing an unprecedented nursing shortage. A Northwest Health Foundation study released this year found that Oregon alone will have 3,200 nursing vacancies in 2010. It is critical that we act immediately to address this shortage, and we must start by retaining the highly skilled nurses that already constitute the foundation of our health care system.

Our Nation's nursing shortage is not merely the result of poor nurse recruitment, this shortage exists in large part because nurses are leaving the profession altogether. Half a million licensed nurses are not currently practicing. These nurses represent some of our Nation's most compassionate and experienced health care professionals, but they feel compelled to look elsewhere for work, and we must do something to change this disturbing trend.

The Nurse Retention and Quality of Care Act will give hospitals incentives to develop and implement model practices for retaining nurses, such as the methods used by ''magnet hospitals''. Magnet hospitals have been in existence for a number of years, and share certain characteristics designed to make these hospitals attractive workplaces for nurses. These hospitals promote nurse participation in decision-making, collaboration and communication among health care professionals, opportunities for nurses to pursue education and career advancement, and a balanced and accommodating work environment for nurses.

Nurses in magnet hospitals stay twice as long on average as those in non-magnet hospitals, and consistently report greater job satisfaction. Patients also express higher satisfaction in magnet hospitals. There is one such hospital in my home state of Oregon, Providence St. Vincent Medical Center in Portland, OR, and I am not alone in hoping this legislation will lead to additional magnet facilities. Our legislation will authorize $40 million in demonstration grants for health care facilities to implement the model practices

utilized by magnet hospitals, and I believe that this will be an important step toward fixing our Nation's impending nursing shortage.

Nurses are the human face of medicine, but the demands on them are increasingly difficult to bear. The Nurse Retention and Quality of Care Act paves the way for hospitals to implement practices that will improve the morale of nurses and encourage them to stay in the nursing profession. Now, more than ever, with the current health and safety concerns facing our Nation, we must let nurses know that they are important to us and that we value their expertise and compassion. By passing this bill, we can do just that, and take important steps to ensure an adequate supply of highly qualified nurses for years to come.

STATEMENTS ON SUBMITTED RESOLUTIONS

SENATE CONCURRENT RESOLUTION 80—EXPRESSING THE SENSE OF CONGRESS REGARDING THE 30TH ANNIVERSARY OF THE ENACTMENT OF THE FEDERAL WATER POLLUTION CONTROL ACT

Mr. BOND (for himself, Mr. GRAHAM, Mr. VOINOVICH, Mr. JEFFORDS, and Mr. CRAPO) submitted the following concurrent resolution; which was referred to the Committee on Environment and Public Works:

S. CON. RES. 80

Whereas clean water is a natural resource of tremendous value and importance to the United States;

Whereas there is resounding public support for protecting and enhancing the quality of the rivers, streams, lakes, wetland, and marine water of the United States;

Whereas maintaining and improving water quality is essential to protecting public health, fisheries, wildlife, and watersheds, and to ensuring abundant opportunities for public recreation and economic development;

Whereas it is a national responsibility to provide clean water for future generations;

Whereas substantial progress has been made in protecting and enhancing water quality since the date of enactment, in 1972, of the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.) due to concerted efforts by Federal, State, and local governments, the private sector, and the public;

Whereas serious water pollution problems persist throughout the United States and significant challenges lie ahead in the effort to protect water resources from point sources and nonpoint sources of pollution;

Whereas further development and innovation of water pollution control programs and advancement of water pollution control research, technology, and education are necessary and desirable; and

Whereas October 2002 is the 30th anniversary of the enactment of the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.): Now, therefore be it

Resolved by the Senate (the House of Representatives concurring), That, as the United States marks the 30th anniversary, in October 2002, of the enactment of the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), Congress encourages the people of the United States and all levels of government to recognize and celebrate the accomplishments of the United States under, and to recommit to achieving the goals of, that Act.

Mr. BOND. Mr. President, it is a pleasure for me to submit a concurrent resolution with the House of Representatives to commemorate the 30th anniversary of the Clean Water Act next October 2002. Representative SHERRY BOEHLERT is introducing the House version and joining me in the Senate are Senators CRAPO, GRAHAM, and VOINOVICH.

Every time we look out onto a river, swim in a lake, or cast a line in search of a fish, we have the Clean Water Act to thank. Streams that were once devoid of fish and other aquatic life now support numerous and varied aquatic populations. Lakes that were once choked by pollution are now vastly improved. Wastewater discharges from municipal and industrial sources are being controlled.

One of the first and most successful national environmental laws to be passed by the Federal Government, the Federal Water Pollution Control Act, commonly known as the Clean Water Act, was enacted in 1972 and set the goal of restoring and maintaining the chemical, physical, and biological integrity of the nation's waters. In the nearly three decades since its enactment, Clean Water Act programs have yielded measurable improvements in water quality.

We have come a long way, yet much remains to be done to achieve the Acts' goals of ''fishable'' and ''swimmable'' waters. Nonpoint sources of pollution from urban, suburban and rural areas are remain a significant threat to the nation's water resources. Science has given us the ability to detect pollutants in ever decreasing amounts. Technological advances, while providing solutions to pollution problems, also pose new pollution concerns.

Therefore, while commemorating a successful 30 years in clean water, we must also recommit ourselves to solving remaining clean water problems. The time until the 30th anniversary on October 18, 2002, will provide us a year to renew our commitment to clean our waters. As it did in 1992, America's Clean Water Foundation, ACWF, will coordinate the Year of Clean Water with activities: 1. highlighting the need to enhance collective appreciation for the importance of our water resources, 2. educating our nation's youth 3. building a better understanding of remaining challenges and solutions, and 4. rekindling the stewardship ethic begun in the 1970's.

The Year of Clean Water activities, scheduled throughout 2002, will provide the opportunity for citizens and governments to come together in support of clean water and water resource protection programs. For example, program planning is under way for a World Watershed Summit, a Youth Watershed Summit, a National Stormwater Conference, a Legal and Economic Issues Forum, and a national water quality monitoring effort to gather water quality data from around the country. Please join me in support this legislation.

SENATE RESOLUTION 174—EXPRESSING APPRECIATION TO THE UNITED KINGDOM FOR ITS SOLIDARITY AND LEADERSHIP AS AN ALLY OF THE UNITED STATES AND REAFFIRMING THE SPECIAL RELATIONSHIP BETWEEN THE TWO COUNTRIES

Mr. MILLER (for himself and Mr. HELMS) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 174

Whereas the United Kingdom has been a stalwart and loyal ally to the United States;

Whereas in response to the September 11, 2001 terrorist attacks on the United States the Prime Minister of the United Kingdom, Tony Blair, declared that ''America is our closest ally and friend. The links between our two peoples are many and close and have been further strengthened over the last few days. We believe in Britain that you stand by your friends in times of trial just as America stood by us'';

Whereas the United Kingdom has worked with the United States to build and consolidate an international coalition of countries determined to defeat the scourge of terrorism;

Whereas Prime Minister Tony Blair and other senior officials of the Government of the United Kingdom have personally traveled to foreign capitals, including Moscow, Islamabad, and New Delhi, as part of the effort to build this international coalition; and

Whereas British military forces participated in the initial strikes against the Taliban and the Al Qaeda terrorist network and continue to fight side by side with United States forces in this war against terrorism: Now, therefore, be it

Resolved, That the Senate—

(1) extends its most heartfelt appreciation to the United Kingdom for its unwavering solidarity and leadership as an ally of the United States; and

(2) reaffirms the special relationship of history, shared values, and common strategic interests that the United States enjoys with the United Kingdom.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2017. Mr. HARKIN (for himself and Mr. SPECTER) proposed an amendment to the bill H.R. 3061, making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2002, and for other purposes.

SA 2018. Mr. CHAFEE submitted an amendment intended to be proposed by him to the bill H.R. 3061, supra; which was ordered to lie on the table.

SA 2019. Mr. FEINGOLD (for himself and Ms. COLLINS) submitted an amendment intended to be proposed by him to the bill H.R. 3061, supra; which was ordered to lie on the table.

SA 2020. Mr. DOMENICI (for himself, Mr. WELLSTONE, Mr. KENNEDY, Mr. REID, Ms. STABENOW, Mr. AKAKA, Mr. BAUCUS, Mr. BAYH, Mr. BENNETT, Mr. BIDEN, Mr. BINGAMAN, Mrs. BOXER, Mr. BREAUX, Mr. BYRD, Ms.